

A PHENOMENOLOGICAL STUDY OF CLINICIANS TREATING TRAUMAGENIC
COMPULSIONS RESULTING FROM CHILDHOOD SEXUAL ABUSE

by

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Abstract

Various types of traumatic compulsive behaviors have been observed by practicing mental health clinicians and yet there is a lack of consensus among such clinicians for treating people in such a problematic state when there is also a history of childhood sexual abuse. Ten seasoned clinicians, each with over 15 years experience in treating patients with traumagenic compulsions and childhood sexual abuse were interviewed to explore their lived experience treating people with traumagenic compulsions due to childhood sexual abuse. A phenomenological design was used to assess the data collected in the study. The data were analyzed to determine the best prevention, intervention, and treatment (PIT) practices that could be used to assist persons diagnosed with traumagenic compulsive behaviors and childhood sexual abuse. The first research question yielded a variety of responses that showed the use of formal assessment measures, behavioral observations, and formal interviews to assess for traumagenic compulsions. The second question found a respect for patient guardedness as an attempt for the patients to protect themselves from further harm. A crucial finding was the lack of reimbursed time to explore the full dynamics of compulsive behaviors and emotional attachment. The third question yielded terms like *power, control, fixated, depth of pain, and lack of power* in describing the treatment process. The therapists were cognizant of the resistance and guardedness of patients there to deal with other symptoms; as the patients generally may not volunteer their own compulsive behaviors. A general consensus of clinicians emerged so as to delineate the link between childhood sexual abuse and compulsive collecting and compulsive hoarding. Thus, a starting point for a treatment protocol was established and provided a recommendation for future research.

Dedication

To my love and my wife, Carrie, as we serve Him together.

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My profound sense of acknowledgment could not possibly thank the ones who helped me through this, or the restaurants and cafes where this work was produced. To the Lord, first of all I want to say thanks so very much for getting me through so much in my life. Thank you for giving me Life more abundantly. To my love and my wife, Carrie, thank you so profoundly for so much. To my church family, I appreciate you so much and love you in all that I do. To my colleagues and clients and friends who listened to me talk on and on and on so I could express these ideas more clearly. To the colleges and universities, and to the schools before them, thank you for doing so much and sacrificing so much so that I could learn. To Dr. Ben Noah, Dr. Mary C. Rockey, and Dr. Amy Donovan and all of Capella University, I owe you a profound sense of deepest gratitude beyond more than I can express. To my family-of-origin, I had to endure so that I could help others, and thanks for asking forgiveness as it is all yours!

Table of Contents

Acknowledgments	iv
CHAPTER 1. INTRODUCTION	1
Introduction to the Problem	1
Background of the Study	2
Statement of the Problem	5
Purpose of the Study	7
Rationale	8
Research Questions	10
Significance of the Study	10
Definition of Terms	12
Assumptions and Limitations	14
Nature of the Study	15
Organization of the Remainder of the Study	17
CHAPTER 2. LITERATURE REVIEW	19
Introduction to the Literature Review	19
Theoretical Framework	21
Review of the Critical Literature	24
Evaluation of Viable Research Designs	36
Chapter 2 Summary	45
CHAPTER 3. METHODOLOGY	50
Research Design	50
Sample	55

Instrumentation/Measures	58
Data Collection Procedures	59
Data Analysis	61
Ethical Considerations	63
CHAPTER 4. DATA COLLECTION AND ANALYSIS	66
Introduction	66
Research Questions	67
Results	68
Findings	70
Findings for the First Research Question	70
Findings for the Second Research Question	74
Findings for the Third Research Question	76
CHAPTER 5. DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS	80
Introduction	80
Discussion of the Findings	80
Relationship of the Findings to the Literature Review	85
Recommendations for Future Study	87
Conclusion	89
REFERENCES	90
APPENDIX A. INTERVIEW PROTOCOL	97
APPENDIX B. COVER LETTER DEAR COLLEAGUE WITH ATTACHMENTS	100

CHAPTER 1. INTRODUCTION

Introduction to the Problem

According to Heim et al. (2000), obsessive compulsive behaviors (OCD) occur as a result of post traumatic stress disorder (PTSD). Heim et al. focused on the clinical treatment of the adverse effects of childhood sexual abuse that results in behavioral manifestations of OCD in childhood, adolescence, and adulthood. Heim et al. examined childhood sexual abuse that causes childhood PTSD and the clinical treatment of the combined disorders of PTSD and OCD. The term of childhood as 12 years old and under, which is generally before puberty was used (Heim et al.). Puberty marks significant brain changes that seem to “lock in” certain behaviors and drives (Heim et al.). While many people engage in collecting behaviors that are considered to be within normal limits (Frost et al., 2003), there has been relatively little research directed at the people who compulsively collect or compulsively hoard who have also been sexually abused as children (Hartl, Duffany, Allen, Steketee, & Frost, 2005). In addition, Crosson-Tower (2005) referred to compulsive behaviors due to trauma as traumagenic compulsions. Various types of traumatic compulsive behavior have been observed by practicing mental health clinicians in some individuals due to childhood sexual abuse enacted upon them. However, there is a lack of consensus among such clinicians for treating these patients.

Accordingly, prevention, intervention, and treatment (PIT) are a three-pronged approach needed to reduce the incidence of traumagenic compulsions. First, prevention

entails education and community awareness (Crosson-Tower, 2005). Along with prevention, Crosson-Tower noted that intervention incorporates legislation, law enforcement, criminal justice, adjudication, and child protective services. Lastly, treatment consists of psychotherapy, counseling, behavior therapy, intensive family therapy, crisis intervention, family systems psychoeducation, foster placement, adoption, social work, and human services, as well as medical services (Crosson-Tower). Childhood sexual abuse that causes PTSD is difficult to treat and a treatment protocol needs to be developed when additional behaviors like compulsive collecting or compulsive hoarding are present as well (Crosson-Tower).

Background of the Study

The focus on treatment is an attempt to obtain information from clinicians that is crucial to have before such prevention, intervention, and treatment protocols can be developed in order to reduce the incidence of traumagenic compulsions (Crosson-Tower, 2005). In order to utilize prevention, intervention, and treatment, research is also necessary to practice and to implement them effectively. Frost, Steketee, and Greene (2003) established a possible link between compulsive collecting and compulsive hoarding with childhood abuse. Hicks and Sales (2006) found a difference in the collection patterns of people. Hicks and Sales found that while most people collect within normal limits, a small percentage may not be able to say “enough” and stop collecting. Thus, a percentage of people seem to *compulsively collect* places, property, food, and other items in detailed collections; the authors contend that typical collecting in general is non-life-threatening. In more extreme cases, Hicks and Sales demonstrated that some

people *compulsively hoard* people, as in the history of some serial killers prior to or during their murder sprees as being life-threatening. According to Hicks and Sales, in their profiling of serial killers, there is a period of time during which the perpetrators collect living people around them to be followers. Having an entourage of followers collected seems to be a way the perpetrators motivate themselves to do their crimes (Hicks & Sales). In other cases noted by Hicks and Sales, compulsive collecting and compulsive hoarding may exist in milder collections that are not life-threatening. There is a problem in that collecting and hoarding are used interchangeably in the field, whereas a distinction needs to be made (Hicks & Sales).

Compulsive collecting that jeopardizes the financial health, or storage capability, of the individual and family can include collections of food, junk cars, junk items, or any items that exceed the possible use in a lifetime (Hicks & Sales, 2006). The compulsive aspect is seen in the inability to say “no” to more possessions (Hartl et al., 2005; Hicks & Sales). Other types of compulsive hoarding that are life-threatening include excessive pet collections, food to spoilage (affecting the health of inhabitants and neighbors), and also includes the inability to say “no” to more even though lives are at stake (Hicks & Sales). Other distinctions need to be made, such as people with narcissistic personality disorder who may have compulsions to keep many, many friends for unhealthy reasons as part of the personality disorder, but generally they will respond to CBT therapy alone (Hicks & Sales). However, people with PTSD due to CSA and who also compulsively collect or compulsively hoard, and have any type of personality disorder, will generally not respond to CBT alone.

The most serious limitation was the regional limitations of the respondents in this study and the lack of response from participants from a national base. Further research was accomplished, though regional and not national, as follows to see whether the compulsive aspect is life-threatening or non-life-threatening according to Frost et al. (2003). Hicks and Sales (2006) repeatedly noted there is scant research on the topic, especially where childhood sexual abuse is involved. The question as to whether the ubiquitous damage in various facets of development due to childhood sexual abuse can be reversed also warrants further research (Hicks & Sales, 2006). According to Heim et al. (2000), there are key signals of damage in all three human physiological systems (central nervous system, endocrine system, and immune system) that are persistent throughout the person's lifespan. In fact, people may reenact the trauma during significant events or significant annual anniversaries corresponding to the years when the abuse and neglect occurred (Ney, 1988; Ney, Fung, & Wickett, 1994). Hicks and Sales found that there have been consistent themes and findings in victims of childhood sexual abuse (CSA) before age twelve, and that either compulsive collecting or compulsive hoarding can develop in this population within this developmental time frame (Ney, Fung, & Wickett).

Ney, Fung, and Wickett (1994) found that developmental histories show that people with PTSD due to CSA may compulsively collect toy soldiers, toy cars, rocks, clocks, or any items that are intertwined to the childhood sexual abuse. Hicks and Sales (2006) pointed out that since the survivors are considered a vulnerable population, little recent research has been performed, and treatment has been difficult. The reason there is very little research specific to this group exists is because survivors of childhood sexual

abuse are considered a vulnerable population. Also, Hicks and Sales noted that this is also emphasized in the Collaborative Institutional Training Initiative (CITI) modules training. Yet, in conjunction with the findings of Hicks and Sales, once the CSA issues were resolved, the collecting or hoarding stopped. Heim et al. (2000) documented that childhood sexual abuse that causes post traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), and notable brain damage observed in brain scans. Hicks and Sales found that there is a spectrum that compulsive collecting may lead to compulsive hoarding. The progression itself may indicate the presence of CSA trauma that occurred before the age of 12 years.

Statement of the Problem

A lack of research leads to inconsistent and less successful therapeutic approaches as noted by Hicks and Sales (2006). Various types of traumatic compulsive behavior have been observed by practicing mental health clinicians in some individuals due to childhood sexual abuse enacted upon them. However, there is a lack of consensus among such clinicians for treating people in such a problematic state. Hicks and Sales contend that typical collecting in general is non-life-threatening and within normal limits and treatment for either is not to be the same approach. Hicks and Sales directed future research to look at the delineation of (a) collecting, (b) compulsive collecting, and (c) compulsive hoarding as three behavior groups. This study attempted to see how seasoned clinicians delineate the terms, if, in fact, they do. In addition, according to the National Study Group on Chronic Disorganization (NSGCD; 2003), the four categories of evaluation include structure and zoning issues, pets and rodents, household functions, and

sanitation and cleanliness. Also, there are five levels that indicate the level of severity. Typical collecting behavior would fall into level I or II on NSGCD's scale. On the other hand, there may be a developmental progression among people, some with histories of childhood sexual abuse, to compulsively collect (NSGCD level III) and then even compulsively hoard. Unlike compulsive collecting, compulsive hoarding is a life-threatening behavior, which when evaluated according to NSGCD's scale, would fall into level IV or V (Frost et al., 2003; Hicks & Sales, 2006; NSGCD, 2003; Pope & Brown, 1998). This study noted how the seasoned clinicians incorporate this information into their practice.

Thus, theory is to drive prevention, intervention, and treatment for any modality in any area to work (Hicks & Sales, 2006; Joachim, Lyon, & Farrell, 2003). This study focused on the theory according to Joachim et al., to first use traumagenic resolution therapy (TRT) with the client, and *then* cognitive behavior therapy (CBT) to effectively reduce the compulsive collecting or compulsive hoarding behaviors while enhancing the clients' lives overall. The order of the two treatment modalities may make a difference as also using only one treatment modality will be ineffective. Joachim et al. did not study this particular axiom of the theory, but conjectured that one modality alone would be found to be ineffective. Further, they stated that the wrong order of the two modalities would cause negative symptoms to increase. They postulated that if the correct order and procedures are used, patients in effective treatment protocol would move in stages from victim, to survivor, to thriver. This study noted how the seasoned clinicians incorporated this theoretical postulate into their practice.

Purpose of the Study

The purpose of this study was to determine how clinicians treat people with compulsive behaviors following traumas associated with childhood sexual abuse. According to Joachim, Lyon, and Farrell (2003), more research is needed in reducing the traumagenic compulsive behaviors that can provide constructs to direct future research in looking at treatment alternatives. This qualitative research study interviewed clinicians who have treated traumagenic compulsions in patients with a history of childhood sexual abuse. The interviews of clinicians treating this population had positive implications for the practice of treating traumagenic compulsive behaviors in patients with a history of childhood sexual abuse. The study proposed to interview clinicians to see what patterns qualitatively emerge in the successful treatment of persons with PTSD due to CSA who compulsively collect or compulsively hoard, as collecting and hoarding are along a spectrum of behaviors.

The goals of this research were

1. To shed light on how seasoned clinicians assess and treat traumagenic compulsions in those patients who have a history of CSA, childhood being defined as age 12 years old and under.
2. To identify the most significant obstacles or resistance in treating those patients who have a history of CSA and who compulsively collect and hoard.
3. To obtain the clinicians' experiences and narratives on how both CBT and traumagenic resolution therapy helps those patients who have a history of CSA and who compulsive collect or compulsively hoard.

Rationale

Hicks and Sales (2006) posited that future research needs to examine the connection between compulsive collecting and compulsive hoarding patients with a history of childhood sexual abuse trauma before the age of 12 years, as a general rule before puberty. There is scant literature available on the pertinent theme. Hartl et al. (2005) concurred with the experiences of some of the clinicians and survivors that the presence of compulsive collecting and compulsive hoarding might be an indicator of childhood sexual abuse trauma before the age of 12 years. Compulsive collecting and compulsive hoarding may be the result of other factors, such as minimal brain traumatic injury, genetics, or organic conditions as well (Hartl et al.). The authors noted that the treatment protocols for each condition and concurrent etiology need to vary. One treatment does not fit all. At present, some clinicians may be using incorrect protocol in the absence of acceptable evidence-based practices, especially in this population.

In order to delineate acceptable evidence-based practices, studies in various disciplines may be helpful. Ney (1988) and Ney, Fung, and Wickett (1994), along with Lochner et al. (2005), assert that thoughts determine or influence behaviors. They assert that the antecedent of an event determines the thoughts that precede the actions people take and is traced back to the James-Lange theory of the 19th century. Compelling evidence within the literature supports this position (Lochner et al., 2002; Lochner, et al.). In the same manner, studying the environments and the responses of living human beings has created the field of psychoneuroimmunology. Maier, Watkins, and Fleshner (1994) demonstrated that attitude is a major factor in contracting disease. The better attitude one

has, the more disease susceptibility is reduced, and thereby healing occurs at a faster rate (Ney; Ney, Fung, & Wickett).

When the patient's conclusions are revealed, this may assist in the cessation of the behaviors. Similarly, Antonovsky's sense of coherence theory (as cited in Joachim, Lyon, & Farrell, 2003) described behaviors of people as purposefully maintained coping mechanisms, in an attempt to achieve balance and coherence in their life. If harmful coping skills are utilized due to the patient's distorted conclusions, traumagenic compulsions may become life-threatening, but the purpose of the behaviors needs to be explored before the behaviors can be gradually decreased. Thus, Joachim, Lyon, and Farrell stated that treatment that is researched needs to go beyond what most modalities provide, in order to help patients find coherence, using non-compulsive coping mechanisms. In fact, they found that some treatments may leave the patients with other problems to contend with and that is not successful treatment.

Further, this was a phenomenological study of clinicians who responded and who each have had over 15 years of experience. This study was intended to yield patterns that emerged from the responses of the structured interview of the seasoned clinicians that will hopefully shed light on successful treatment methods. This was similar to an approach done by Skovholt and Jennings (2003) to study master therapists' approaches to treatment in general and to study the self-care of these master therapists. The approach used herein was to alter the approach of Skovholt and Jennings by not pre-selecting the therapists as Skovholt and Jennings did, but rather by appealing to several clinical membership associations to see who responded to the call by criteria to complete a structured phone interview. Also, this study used the term seasoned clinicians rather than

the Skovholt and Jennings term of master therapists. This experience of responding to such interviews over the years and participating in other types of research helped the primary researcher to shape this intended study.

Research Questions

1. How do clinicians assess and treat traumagenic compulsions in patients who have a history of childhood sexual abuse?
2. How do clinicians describe positive and negative outcomes in treatments of patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard?
3. What are the most significant obstacles or resistance in treating patients who have a history of childhood sexual abuse and who compulsive collect or compulsively hoard?

Significance of the Study

The study noted significant aspects of theory. Just as attitude may affect a patient's susceptibility to contracting disease, other studies highlight observations which may also help in defining acceptable evidence-based practices. Maier, Watkins, and Fleshner (1994) found that when normal development in human beings occurs, the central nervous, endocrine, and immunologic systems work in concert. They also found that when child abuse and neglect occurs, these internal systems do not develop correctly, resulting in imbalance. Berkowitz (1993) presented a history of the James-Lange Theory to demonstrate what is involved in the formation of angry feelings and to show that

simply expressing feelings without changing cognitive processes is often non-productive. Berkowitz showed that the use of the James-Lange Theory in the treatment of being aggressive and from the survival of aggressive acts, feelings need to be vented as in TRT and cognitions need to be changed as in CBT. This may describe the result in Hartl, Duffany, Allen, Steketee, and Frost (2005) who found that an emotional attachment to possessions may ensue as an attempt to balance the systems to fill an emotional void brought about by sexual aggression, whether in the perpetrator, the survivor, or one who has a history of both. Further, this demonstrates that sexual aggression on a person before puberty, will have additional deleterious effects in the survivor as a function of human development that may seem irreversible (Berkowitz; Hartl et al.).

Another element to discerning acceptable evidence-based practices is measuring the pliability of behavior patterns. Ney, Fung, and Wickett (1994) noted that any complex relational habits learned before age 12 do not readily respond to the individual's attempts to change them. Ney, Fung, and Wickett used the example that when one learns a foreign language before age 12 there is no discernable accent in any of the languages. Conversely, if one learns a foreign language after age 12, there is a discernable accent of the first learned language in the foreign language. Even addictions begun before age 12 years are far more difficult to change than addictions formed after age 12 (Maier, Watkins, & Fleshner, 1994). When assessing the rigidity of self-destructive behaviors and determining appropriate treatment (Lochner et al., 2002, 2005) trained clinicians should assess both actions and words when uncovering the past of patients, and not by words alone. The family of origin narratives displays the conflicts with the behavioral pictures that have emerged over the years in the lives of patients as well (Hartl et al., 2005).

Behavioral pictures from the lives of patients depict patterns by which positive evidence-based practices may be developed. Ney (1988) was the first to publish the indication that as the three human biologic systems develop those first 12 years of life, memories and events are catalogued in a way that the person projects the experiences. In fact, Ney and later Ney, Fung, and Wickett (1994) are the only researchers to have found a most poignant fact that people repeat the cycles of non-resolved memories on significant anniversary dates of the abuse. The cycles of self-destructive behaviors that occur are called entropic reenactment (Ney, 1988; Ney, Fung, & Wickett, 1994).

Modalities of traumagenic resolution therapy assist the patients by engaging the patients to talk about the trauma and the pattern of entropic reenactment, thus preventing the continuation of the patterns by resolving the core issues (Hartl et al., 2005; Lochner, et al., 2005; Ney, 1988; Ney, Fung, & Wickett, 1994). Traumagenic compulsions, therefore, need to be treated with a combination of traumagenic resolution therapy first since traumatic reactions are precognitive and then followed by cognitive behavior therapy (Hartl et al., 2005; Lochner, et al., 2005).

Definitions of Terms

Childhood sexual abuse. Childhood sexual abuse is any type of fondling, molestation, or sexual exposure, whether or not involving penetration, to a child under age 12 years old, according to Friedrich, Grambsch, Broughton, Kuiper, and Beilke (1991).

Cognitive behavior therapy (CBT). Seligman (2006) noted that CBT helps patients change their thinking to change their actions. Coping is thinking about negative

thoughts in a framework of how to correct those thoughts and stop believing the old ones (Seligman, 2006). Specifically, the cognitive distortions include magnification of the negative, imperatives, all-or-nothing thinking, and negative forecasting. Cognitive behavior therapy is a treatment system requiring goal-setting and action plans using the tools of journaling and thought logs.

Compulsive collecting. For the purposes of this study, compulsive collecting is non-life-threatening while compulsive hoarding is life-threatening. The behavior set of compulsive collecting still contains the presence of compulsivity that is beyond what is seen within normal limits, such as hobby collections. The person does not seem to be able to say “no” to the compulsive impulses, thoughts, or actions.

Compulsive hoarding. The presence of compulsive hoarding will be generally defined as having the components of being a multifaceted problem that pertains to problems with information procession, with attachment and strong beliefs pertinent to saving possessions, the avoidance of distress associated with discarding or making decisions about possessions, and the presence of excessive acquisition and difficulty in discarding possessions (Frost, Steketee, & Greene, 2003). Also, compulsive overeating is an example of compulsive hoarding as well since it is excessive food storage beyond use to spoilage and as such is life-threatening. Things and pets are hoarded to extremes beyond useable collections.

Seasoned clinicians. For the purpose of this study, the clinicians who respond will fit the criteria of having experience treating patients with a history of childhood sexual abuse by greatly reducing their traumagenic compulsions, to the extent that the reduction of the behaviors may be measured by a lessening of numbers of incidents and by

lessening in severity. The seasoned clinicians will have experience in evaluations and treatment of people with a history of childhood sexual abuse. Seasoned clinicians with over 15 years of experience have generally developed beneficial protocols and productive methods of treatment (Skovholt & Jennings, 2003). The same clinicians have also identified what methods are not beneficial and productive, whereby they have seen patients repeatedly relapse or to maintain relapse-free levels.

Traumagenic compulsions. Greenough, Black, and Wallace (1987) demonstrated how negative experiences adversely affected brain development in children. As a result, the ability to control negative behaviors was reduced and traumagenic compulsions emerged. According to the authors, traumagenic compulsions are systemized patterns of behavior formed out of the patient's conclusions. These patterns of behavior are the patient's attempt to prevent the abuse from occurring again, or avoid the feelings associated with the trauma.

Traumagenic Resolution Therapy (TRT). Seligman (2006) described traumagenic resolution therapy (TRT) as any modality of psychotherapy that permits patients to talk about their abuse, in order to find resolution for the issues the abuse created. Schmelter-Davis (2004) defines talk, whether in pictures or in words, as thinking out loud. The authors contend that thinking out loud leads to metacognition, which subsequently leads to resolution.

Assumptions and Limitations

The accuracy and veracity of the clinicians, both in identifying themselves as treating this population and in the content of the responses, was verified through

qualitative research techniques (Sproull, 2002). The content of the feedback was hopefully beneficial to direct future research. There is scant research to cite in connecting childhood sexual abuse to compulsive collecting and compulsive hoarding. Further, there is very little research in the clinical treatment of people with traumagenic compulsions and a history of childhood sexual abuse, because they are a vulnerable population. Therefore, much of the data and research cited in this study may be dated or singularly expressed.

The vulnerable population represented by those who have endured childhood sexual abuse has not been frequently studied (Crosson-Tower, 2002; Scannapieco & Connell-Carrick, 2005). Traditional cognitive behavior therapy is usually ineffective in a percentage of participants in any study (Lochner et al., 2002). Since the childhood histories are not obtained in the studies, it is uncertain as to the comparison of adverse childhood experiences to the lack of using evidence-based protocol and treatment in some people. Perhaps, those participants who did not respond to treatment in prior studies had a history of CSA. The study was patterned as something needed to begin to develop a protocol for this specific group of patients (Hicks and Sales, 2006).

Nature of the Study

This phenomenological research was a preliminary examination that was intended to lead to a format for developing a protocol that needs to be conducted to determine appropriate treatment for patients who display compulsive collecting and compulsive hoarding, and who have also experienced childhood sexual abuse trauma before the age of 12 years as noted by Hartl et al. (2005) . Also, human services workers

in general practice need to be aware of childhood sexual abuse prevention, intervention, and treatment (Crosson-Tower, 2005; Ney, 1988; Ney, Fung, & Wickett, 1994). The professional and personal experiences of the clinicians and patients, as noted by Hicks and Sales (2006), found that the presence of compulsive collecting and compulsive hoarding may be an indicator of childhood sexual abuse trauma before the age of 12 years. Treatment providers may inadvertently be doing more damage to people with traumagenic compulsions by attempting to treat survivors with traditional cognitive behavior therapy or by even more adverse treatments for survivors like implosion, or partial implosion (Hartl et al., 2005).

Researchers and clinicians could perhaps benefit from studies aimed at the effects of both modalities in the treatment of traumagenic compulsive behaviors in patients with a history of CSA, as noted by Hartl, Duffany, Allen, Steketee, and Frost (2005). Yet, there is little research as to how clinicians have helped to reduce traumagenic compulsive behaviors using a combination of cognitive behavior therapy and traumagenic resolution therapy in patients with a history of childhood sexual abuse (Hicks & Sales, 2006; Joachim, Lyon, & Farrell, 2003). The problem is that some clinicians have treated persons with CSA histories and PTSD in a manner that significantly increased compulsive behaviors along with increasing other distressing symptoms by using implosion. Implosion, which is to take all the things away at once, produces more problems as patients will report that it feels like rape all over again (Joachim, Lyon, & Farrell). According to Joachim et al., usually further decompensation of the individual with PTSD due to CSA follows implosion. Implosion may work on some people, but

Joachim, Lyon, and Farrell warned that it will not work on this group of patients with CSA and PTSD.

Current trends of treatment, both behavioral and psychopharmacologic, that include a wide variety of approaches, show efficacy rates of only 60 to 75%. This is intriguing as that rate of childhood sexual abuse is 25% of children (Crosson-Tower, 2005). Perhaps, the “failure” rates are an overlap of the group of CSA survivors who may need a unique treatment approach. This possibility is unknown as the research participants are not screened for CSA before the research as that would prohibit the research due to the identification of a vulnerable group. Clinicians need more research to direct their treatment of compulsive collecting and compulsive hoarding in patients with a history of CSA (Crosson-Tower). As Frost, Steketee, and Greene (2003) showed it may be that the people with traumagenic compulsions may not respond to cognitive behavior therapy (CBT) alone. They contend that the group of patients that do not respond to CBT alone may be ones with childhood abuse.

Organization of the Remainder of the Study

The remainder of the study was organized as the pertinent literature review, and then the methodology section. The literature review shows the history and efficacy of various treatment modalities as pertaining to this study. The methodology section will describe the qualitative phenomenological study using the structured interview technique for obtaining data from the seasoned clinicians who respond to the call for research and meet criteria. Chapter 4 presents the data (in the voice of the participants) and an analysis

of the findings. Chapter 5, presents the results, conclusions, and the recommendations for further research..

CHAPTER 2. LITERATURE REVIEW

Introduction to the Literature Review on Traumagenic Compulsions Research

Many authors have stated that when there is a qualitative difference with respect to behaviors and quality of life, then a qualitative method may need to be employed (Berg, 2007; Berrios & Lucca, 2006; Bordens & Abbott, 2005; Choudhuri, Glauser, & Peregoy, 2004; Cozby, 2007; Creswell, 2003). Clinicians need to pursue qualitative research in order to prescribe interventions and treatments that follow the qualitatively described behaviors (Berrios & Lucca). There is a difference between the three positions on the spectrum of collecting behavior. As stated by Anderson, Damasio, and Damasio (2005) and Frost, Steketee, and Greene (2003) the three positions of the spectrum are, (a) typical collecting behaviors in all humans, (b) compulsive collecting behaviors in some humans, and (c) compulsive hoarding in other humans. For example, food is normally collected in bins, baskets, pantries, cabinets, and refrigerators as well as ingested.

However, compulsive overeating can be seen as an example of compulsive hoarding that is life-threatening as relating to types of obesity as offered by Williamson, Thompson, Anda, Dietz, and Felitti (2002). Another example of compulsive hoarding includes excessively storing food beyond use, to spoilage, as noted by Frost, Steketee, and Greene (2003). Items, such as newspapers, may be hoarded to extremes beyond useable collections but jeopardize health. Indoor animals kept in large numbers are often dirty, undersocialized, and generally poorly cared for; parasites and species-specific

disease may be present in the entire population, thus life-threatening. People may be hoarded as well, both living and dead, in documented cases of bone collecting, hair collecting, and items belonging to victims as noted by Hicks and Sales (2006).

Using data from over 60 studies, Pope and Brown (1998) identified that humans can behave in a way that demonstrates a trauma occurred even though the trauma may not be clearly recalled. Trauma memory and recall is reliable, even though slight distortions may exist. Pope and Brown noted that sets of behaviors seen in patients are more indicative of a traumatic event having occurred than just recall by itself. A patient may say that an early childhood incident does not affect them when in fact it does. Pope and Brown found significance in that many behaviors are learned within the first years of life, but the exact means of learning the behaviors may not be recalled by the patient. For example, Pope and Brown noted that any individual adult may not recall eating with silverware or toilet training lessons, but nevertheless continue correctly or incorrectly using silverware or the toilet, depending upon what was learned. Furthermore, another significant finding by Pope and Brown was that in the case of childhood abuse, patients continue the behaviors learned and also remain affected by conclusions made while surviving their trauma. Their conclusions are then evidenced externally through a consistent pattern of behaviors. Therefore, a patient's conclusions made in childhood may be revealed by tracing backward through his or her sets of behaviors, and these are more reliable than recall alone (Ney, 1988; Ney, Fung, & Wickett, 1994; Pope & Brown, 1998).

Theoretical Framework

Romano, Zoccolillo, and Paquette (2006) found that clinicians reported using rapid cognition to discern the difference between three behavior categories such as collecting, compulsive collecting, and compulsive hoarding. According to Romano et al., rapid cognition is the ability of people to rapidly come to correct conclusions by being a seasoned veteran in a particular field. The years of experience enable the seasoned veterans to correctly assess and deploy interventions at speeds that amaze amateurs. Berg (2007) showed that social life operates within fairly consistent behavior patterns that can guide theory. Typologies, therefore, emerge as systematic methods for classifying discrete groupings such as normal collecting, compulsive collecting, and compulsive hoarding. Hartl, Duffany, Allen, Steketee, and Frost (2005) found that the literature is relatively scant in connecting traumagenic compulsive behaviors to childhood sexual abuse. Hartl et al. noted that clinicians generally have not been heard regarding how they successfully treat patients who have both a history of childhood sexual abuse and a history of compulsive collecting or compulsive hoarding behaviors. Those who are researching treatment for compulsive behavior seldom, if ever, query for a history of childhood sexual abuse so as not disrupt a vulnerable population (R. O. Frost, personal communication, May 15, 2006). Frost is a leading psychological researcher in this field of study and a literature search reveals him to be one of the most cited.

Furthermore, there is very little research to cite connecting childhood sexual abuse to compulsive collecting and compulsive hoarding. There is also little research following the clinical treatment of patients with traumagenic compulsions and a history of childhood sexual abuse. Various types of traumatic compulsive behavior have been

observed by practicing mental health clinicians in some individuals due to childhood sexual abuse enacted upon them. However, there is a lack of consensus among such clinicians for treating people in such a problematic state. Lochner et al. (2002) obtained data that asserted the traditional cognitive behavior therapy is usually ineffective in a percentage of participants within any study. Participants' childhood histories are generally not obtained in studies. It is difficult, or impossible, to correlate a relationship between adverse childhood experiences and a lack of response to treatment in some patients. In 2006, The Centers for Disease Control began to assess for adverse childhood experiences. However, findings of treatment are still lacking for many vulnerable populations (CDC, 2006a). Although this may be helpful to specifying evidence-based practices, more clinicians in diverse fields have successfully combined both cognitive behavior therapy and traumagenic resolution therapy, but concise research data is lacking and is perhaps needed (Romano, Zoccolillo, & Paquette, 2006; Rucklidge, Brown, Crawford, & Kaplan, 2006).

Lochner et al. (2002) wrote that when children of any age suffer from childhood sexual abuse, traumagenic compulsive behaviors usually develop. These behaviors may develop into compulsive collecting (non-life-threatening) or compulsive hoarding (life-threatening). Lochner et al. suggested a correlation between childhood sexual abuse and compulsive collecting and compulsive hoarding. Compulsive collecting and compulsive hoarding occurring after childhood sexual abuse may impact biophysiological, psychological, emotional, and relational systems with long-term negative ramifications (Heim et al., 2000; Romano, Zoccolillo, & Paquette, 2006; Rucklidge, Brown, Crawford,

& Kaplan, 2006). Usually, however, when the patient's major issues related to childhood sexual abuse are resolved, the compulsive behaviors cease.

Hartl, Duffany, Allen, Steketee, and Frost (2005) found that the emergence of theoretically viable literature in dealing with traumagenic compulsions has only been published in the last few years. Recently, research has begun to look at the theory and application of traumagenic compulsions (Hartl et al., 2005). Hartl et al. demonstrated that there is a link between traumagenic compulsions and strong emotional attachment to possessions. This attachment to possessions seems to be a type of survival tool for children with adverse childhood experiences. The attachment to and the type of possessions both are significant to the patient with traumagenic compulsions. Hartl et al. clearly call for research into the treatment of these individuals with techniques that differ from those with compulsions attributed to other causes. Hartl et al. stated that the efficacy of treatment of people with traumagenic compulsions needs to be explored. Perhaps in the research literature, up until this time, the failure of cognitive behavior therapy in some cases has been a result of treating people who display traumagenic compulsions using traditional cognitive therapy approaches when they clearly need a different treatment regime.

Scannapieco and Connell-Carrick (2005) have demonstrated how the human services model complements the role of the family when addressing child abuse and neglect. Scannapieco and Connell-Carrick pointed out how various theories can best be employed in the human services model. The authors suggested that the human services model be used in a way that overarches other models. Human services may employ the other models in segments of services. The guiding principle of human services of cultural

competence is part of the best practices that would otherwise be lacking (Price, 2002). Cultural competence is vital in quality human services. With such diversity in America, helping families succeed in raising children requires personal human services for each family in crisis or in need. The human services model listens to the patients and to the seasoned clinicians in treating people and in community health issues like compulsive collecting and compulsive hoarding. Becker (1998) called this method listening to the ones who know the process of research.

The four core areas of human services provision that overlap the issues of child welfare are (a) services to support and strengthen families, (b) protective services, (c) out-of-home services, and (d) adoption services. The focus of human services is the general well-being of children, alleviating suffering, and educating families in need of care. A complementary role by human service providers is needed instead of an adversarial role. The authors du Toit et al. (2001) and Feiring, Taska, and Lewis (2002) found that childhood sexual abuse can lead to individual, family, and community health problems. The human services model can provide a framework for interviewing seasoned clinicians who treat people with traumagenic compulsions and who also have a history of childhood sexual abuse.

Review of the Critical Literature

Scannapieco and Connell-Carrick (2005) draw upon the work of Bowlby and Ainsworth in dealing with a lack of attachment, or the presence of anxious attachment, as a reason for child maltreatment. Perpetrators who abuse children display anxious avoidant, anxious resistant, or disorganized attachment disorders. That is not to say that

any person with an attachment disorder will abuse children, but perpetrators who abuse children have those attachment disorders. Scheider (2000) defined certain behaviors that indicate a parent is likely to abuse. Nonabusive parents do not have these behaviors. Potentially abusive parents will abuse in the near future if an intervention of assistance does not occur. People who display aggression towards children and mistreat them, have several traits in common with perpetrators of abuse. This describes a problem that plagues families and is unfortunately passed through the generations as noted by Scheider. It is deeply entrenched in the dark side of society, which would preferably be avoided by most, rather than discussed, confessed, or treated. The problem is perpetuated through self-hatred or self-contempt. Denial and projection, along with other defense mechanisms, are widespread and keep clinicians and interventionists all rather busy (Hartl, Duffany, Allen, Steketee, & Frost, 2005).

Many of these generational patterns and patterns of self-hatred are not communicated productively. Narrative talk is the coding of a language connection for intrapersonal and interpersonal communication (Schmelter-Davis, 2004). Whether the talk is in pictures or in words, thinking is a complex task that leads to metacognition. When the metacognition phenomenon becomes distorted, all of the relationships within and outside of the self become impaired. This hermeneutic reality is an event that historically has been conveyed for over 6500 years of recorded history. Humans do not easily endure impaired relating for very long, unless the impairment is caused by severe chronic or organic conditions, and must learn to cope with the impaired relating (Schmelter-Davis). Coping, according to cognitive behavior theory, is thinking about the negative within the framework of how to change it and how not to believe the distortion

(Seligman, 2006). Thinking about negative cognitions in order to change them is deliberate. Choosing not to believe negative thoughts is an effective strategy. Journaling and thought logs are also important tools within the philosophy that drives cognitive behavior therapy (Seligman).

Systematic desensitization is another example of CBT's philosophy. Systematic desensitization is one means to overcome all types of fear (Seligman, 2006). For the purposes of this paper, systematic desensitization diminishes the patient's fear of failure and/or the fear of success. Cognitive behavior therapy is a treatment system requiring both goal-setting and action. This could be achieved by using the tools of journaling and thought logs.

Applying cognitive behavior therapy to a larger scale, Tebes (2005) pointed out that community science could be developed to produce lower levels of fear within a community. Once there are clear definitions of the behaviors to be changed, then policies could support the actions necessary to assist the community as a whole. Using accepted, ethical research tools based upon established research theory like the CDC (2006a; 2006b), ACE (Assessment of Childhood Experiences) and the FHHHAQ (Family Health History and Health Appraisal Questionnaires) that use a grounded theory premise could perhaps alleviate suffering and reduce negative social indicators. Theoretical frameworks could guide the use of interventions in certain settings to increase positive social indicators (Thompson & Rudolph, 2000).

Regarding treatment for the individuals within a community, Hartl, Duffany, Allen, Steketee, and Frost (2005) noted that the emergence of theoretically viable literature in treating traumagenic compulsions has only been published in the last few

years. Recently, research has begun to examine the theory and application of treatments regarding traumagenic compulsions (Hartl et al., 2005). In the Hartl et al. research, it has clearly been demonstrated that there is, in fact, a link between traumagenic compulsions and a strong emotional attachment to possessions. Hartl et al. grouped the behavior of attachment to possessions with a type of survival tool for children who experienced adverse childhood conditions. Hartl et al. also documented that the patient with traumagenic compulsion was focused on both the attachment to and the type of possession. Hartl et al. clearly called for research exploring other treatment options. Techniques to lessen compulsive collecting and compulsive hoarding behaviors should differ from those implemented to lessen compulsions attributed to other causes. Implosion, which as a technique would simply rid the patient of the possessions in one sudden event, as an example, will actually do more harm to the patient, as noted in Hartl et al. According to Hartl et al., the efficacy of treatment regarding patients with traumagenic compulsions needed to be explored. Perhaps up until this time, the failure of CBT in research literature, in some cases has been because patients with traumagenic compulsions needed a different treatment regime than those with compulsive behaviors which are due to other etiologies.

The Hartl et al. (2005) research surveyed 36 individuals who met criteria of compulsive hoarding, compared to a control sample of 39 volunteers. The two groups were administered the Saving Inventory – Revised, the Possessions Comfort Scale, the Traumatic Events Scale – Lifetime, the Attention Deficit/Hyperactivity Disorders Scale, and the Cognitive Failures Questionnaire. Groups did not differ in reported severity of traumas or the degree of fear experienced. The significant finding within the continuity

revealed that hoarders more frequently had something taken from them by threat or force, had been physically handled roughly, and were forced to engage in sexual activity before and after age 18 (Hartl et al.)

Another group of researchers (Feiring, Taska, & Lewis, 2002) set out to study the correlations between childhood sexual abuse discovery and the role of shame and attributional style. Feiring, Taska, and Lewis examined the effects of posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and other variables in a multivariate hierarchical regression analysis, rather than a stepwise regression analysis of variables. This is an acceptable practice for social research of the topic matter (Leedy & Ormrod, 2005; Neuman, 2006). The role of shame was studied, revealing statements of perception such as, “What happened to me makes me feel dirty!” and “I feel ashamed because I think that people can tell from looking at me what happened!” The attribution of self blame following childhood sexual abuse fit the researchers’ theoretical understanding of the deleterious effects of childhood sexual abuse. The instruments used were a Systematic Abuse Checklist, the Self-Perception Profile for Children, the Self-Perception Profile for Adolescents, the Children’s Attributional Style Questionnaire – Revised, Abuse Attribution Inventory, the Children’s Depression Inventory, and the Children’s Impact of Traumatic Events Scale – Revised.

Also focusing on the effects of abuse, Feiring, Taska, and Lewis (2002) examined the effects of childhood sexual abuse on 83 children and 64 adolescents over the course of a year. The severity of abuse did not seem to correlate with the outcome, as a result of independent variables of adjustment after the trauma. However, shame and attributional styles accounted for adjustment outcomes. Attribution that was paired with a negative,

pessimistic style correlated most with the highest negative effects of abuse and trauma outcome. The children changed and fluctuated more than adolescents in the course of the year during which they were being studied. It is most significant to note that the patterns of change over time predicted which children would have negative or less negative outcomes. Further, age and gender differences predicted that younger, female children had more negative effects such as shame, posttraumatic stress disorder, and major depressive disorder. The abuse attribution risk seen at the Wave 3 of data collection using time and gender interaction showed that women do blame themselves for abuse more frequently when compared to men over time. The results by Feiring, Taska, and Lewis (2002) specifically noted that the results of this gender attribution over time were significant as demonstrated in the ANOVA analysis results at the significance level .01. The time and gender effects were qualified by a significance level of .05 in the ANOVA analysis.

Although outcome predictors may vary, when clinicians have treated people of any age suffering from childhood sexual abuse, compulsive collecting or compulsive hoarding have been components of the symptom presentation. When the sexual abuse issues are resolved, the traumagenic compulsions have ceased, in the experience of Feiring, Taska, and Lewis (2002). However, the literature is sparse and does not cover the reasons why childhood sexual abuse could cause biophysiological, psychological, emotional, and relational disorders, including traumagenic compulsions. Possibly, the cognition is “Something was taken from me, (i.e. my innocence), so I want to keep all these things around.” Perhaps, the behaviors act as a wall of protection to the patient. It is possible that the patient developed a fixation on an item which created distance from, or

relief from, the immense distress of the sexual abuse. It is also postulated that emotional attachment to objects and possessions is perceived as safe to the patient, whereas an attachment to people is perceived as unsafe. Perhaps, the beginning of these behaviors may be attributed to one or all of the above theories, and it may be related to other cognitions as well. Clinicians will not know the source of these behaviors until more research is done. The research synthesized above indicated that traumagenic compulsions have an extensive development, and when undergoing treatment, the patients need to be handled with the utmost care.

Testa, VanZile-Tamsen, and Livingston (2005) analyzed the lifelong epidemiologic medical and self-report data from 732 women. The data were collected and analyzed in three waves of variables and partners. This provided the hypothesis that women with a history of childhood sexual abuse reported higher levels of sexual risk. The higher levels of sexual risk included assessment on several variables, including greater numbers of sexual partners and greater likelihood of lifetime sexually transmitted infections (STI). In addition, the women had higher levels of partner sexual risk and partner aggression. Five latent variables were included in the model of the study: Childhood Sexual Abuse, Risky Sexual Behavior, Partner Aggression, Partner Sexual Risk, and Relationship Satisfaction. The reliable and valid measures of statistical analysis indicated that childhood sexual abuse causes quantitatively increased problems throughout life, including problems in sexual behavior and core sexual identity. Testa, VanZile-Tamsen, and Livingston indicated that the medical data is more reliable than the self-report data. However, the self-report data is more robust and useful for clinicians.

The level of statistical significance is set at a high value for reliability and validity as according to the summary of the findings.

Another finding of Testa, VanZile-Tamsen, and Livingston (2005) was that patients who suffered childhood sexual abuse have greater numbers of sexual partners, greater frequency of risky sexual behavior, greater incidence of partner aggression, and less relationship satisfaction. Partner Sexual Risk was composed of the woman's estimate of her partner's number of lifetime sexual partners and of his infidelity. Relationship satisfaction included ratings of overall relationship satisfaction, emotional satisfaction, and physical satisfaction. The magnitude of the loadings taken with the indices of fit at a significance level of .001 suggested that the measurement model represents an appropriate fit to the data. Further, these results of the analysis significantly predicted the number of Wave 2 data collection of sexual partners as a function of Wave 1 data relationship quality.

The model of Testa, VanZile-Tamsen, and Livingston (2005) showed a good fit to the data at a significance level of .001. Explained variance (R^2) in relationship satisfaction was .30; R^2 for prediction of Wave 2 data partners was .13. As expected, an increasing severity of childhood sexual abuse was associated to the woman's affiliation with sexually risky and aggressive intimate partners at Wave 1 data. The effect of the increasing severity of childhood sexual abuse was partially mediated via women's higher levels of baseline sexual risk. Partner aggression and sexual risk characteristics were negatively associated with Wave 1 relationship satisfaction, which was also negatively associated with Wave 2 sexual partners. The effects of childhood sexual abuse on relationship satisfaction are mediated via partner characteristics. The direct effects from

childhood sexual abuse and risky behavior were small and insignificant. It follows that sexual satisfaction does not lead to relational satisfaction. Instead, people with childhood sexual abuse have a difficult time finding any satisfaction in a relationship, even in a relationship with high sexual frequencies. Perhaps, this behavior set is also due to a type of compulsive hoarding as it is life-threatening.

Thus, the study by Testa, VanZile-Tamsen, and Livingston (2005) suggested that childhood sexual abuse is debilitating and increases the likelihood of negative outcomes throughout the person's life, including negative outcomes in relationships. As a result, posttraumatic stress disorder (PTSD), major depressive disorder (MDD), and other disorders may develop. These disorders preclude relationships deteriorating in greater frequency. Two factors which are in opposition in relationships are trust versus shame. Trust is crucial to enjoy solid, healthy relationships, while shame erodes relationships. People with childhood sexual abuse have high levels of shame and low levels of trust, according to Testa, VanZile-Tamsen, and Livingston (2005).

Regarding deteriorating relationships, Testa, VanZile-Tamsen, and Livingston (2005) stated that in a comparison between single women and married women, the levels of threat assessment and danger did not support their model. In fact, Testa, VanZile-Tamsen, and Livingston reported that the only difference in paths between the two groups was a significant negative relationship between Wave 1 relationship satisfaction and Wave 2 partners for single women ($-.27, p < .001$). However, this relationship did not attain statistical significance for married women ($-.12, p < .09$). Earlier, they reported greater partner aggression in the married group than the single group. Thus, this finding unfortunately supports the idea that women with aggressive partners simply resign

themselves to accept greater violence as a result of shame and lack of trust (Testa, VanZile-Tamsen, & Livingston).

Although the previously noted data may be helpful to clinicians, Testa, VanZile-Tamsen, and Livingston (2005) cautioned that the data needed to be carefully construed. The married women reported a sense of normalcy with violence, because they were comparing it to their own histories. These findings may be different if the responses came from the general public. When a person has a horrific childhood, experiences which happen to that person in adulthood do not seem bad, relatively, and are reported with less significance (Testa, VanZile-Tamsen, & Livingston, 2005). Likewise, if a person who has not experienced childhood sexual abuse is physically struck in a relationship, she would score that incident as a “5” on a 1 (*mild*) to 5 (*severe*) Likert scale (Testa, VanZile-Tamsen, & Livingston). The person who had experienced childhood sexual abuse would score the occurrence as a “3.” Also, if comparing a single person versus a married person, both having experienced childhood sexual abuse, the married person would score a similar incident as a “2,” and the unmarried person would score the abusive episode as a “3.” These statistics simply indicate the types of interactions and behaviors that the participants have come to expect within their representational model, but it does not necessarily indicate the impact of events. Apparently, seasoned clinicians who effectively treat traumagenic compulsions are able to effectively deal with the numerous issues delineated above. The behaviors and the narratives tell the story, not the narratives alone. The need to “Recognize, Resist, and Report” are important themes in the treatment of survivors as noted by Testa et al.

In another study of the injurious effects of childhood maltreatment and the transmission of negative outcomes that lead to disorders, including traumagenic compulsions, Verona and Sachs-Ericsson (2005) used a mixed methods approach. Both quantitative and qualitative designs were used in a quasi-experimental analysis of intergenerational transmission of child abuse. Patients who abuse their children tend to find blame in other settings, like in the community or at work. For things that go wrong in the house or family, they tend to blame the child(ren) instead of taking responsibility. Patients who externalize often blame their children. The term used by the researchers for external verbal behaviors was externalizing behaviors and was coded as EXT throughout the study. Also, people who are abused are more likely to externalize (EXT) than those not abused. Therefore, reversing externalizing behaviors, such as blaming others, may be the key to treatment by seasoned clinicians to reduce traumagenic compulsions in patients with a history of childhood sexual abuse.

Related to the study of externalizing behaviors, Verona and Sachs-Ericsson (2005) drew data from the National Comorbidity Study of over 8,000 respondents, which was designed to assess the prevalence of psychiatric disorders in the respondents. The semi structured Composite International Diagnostic Interview (CIDI) was conducted by highly trained interviewers. In this study, diagnostic information pertinent to adult externalized behaviors (EXT) was rated. Also, comparisons were made regarding the incidence of negative life events in childhood in relationship to the posttraumatic stress disorder (PTSD) module of the Composite International Diagnostic Interview (CIDI). The Family History Research Diagnostic Criteria was compared with each participant, and a comparison was made by gender as well.

There were also other findings which may be applied. Verona and Sachs-Ericsson (2005) found that some parents place their children at risk for childhood abuse, which then increases their offspring's vulnerability to developing externalized behaviors (EXT) in adulthood. It is most evident in mother-daughter dyads. This work by Verona and Sachs-Ericsson (2005) has profound implications for the delivery of services to at-risk families and children. This study may be very helpful in proving data needed to prevent abuse and the ubiquitous negative outcomes of child abuse and neglect. This research reveals the need to help people take responsibility for their own behaviors in a most compelling methodology. The research also clearly supports the need to gather data of seasoned clinicians who reduce traumagenic behaviors in patients with childhood sexual abuse histories, since traumagenic compulsions are such a complex disorder as shown by Verona and Sachs-Ericsson.

Another advantage of this type of research, exemplified by Verona and Sachs-Ericsson (2005), is that it provides tools most useful to clinicians, educators, and policy makers. In turn, the benefit carries over to the general population, specifically to the children. Another advantage is that it directly produces verifiable data that can help people. One tool is to provide people with needed feedback so they can see the destructive effects of externalized behaviors (EXT) and how often those behaviors are exhibited. The behaviors are even exhibited far more frequently than patients estimate in their own self-evaluation. That finding alone is most noteworthy.

This data can be used in the prevention, intervention, and treatment of child maltreatment. A weakness of the data is that it has to be interpreted for others to clearly understand it. Another weakness of the study is that data can be erroneously distorted into

complicated externalized behaviors (EXT) of its own. On the other hand, the design strength of the Verona and Sachs-Ericsson (2005) study is in that the data cannot be readily misused. Finally, the findings can cause individuals to examine their behaviors, however, that may repel some individuals instead of drawing them to change.

Evaluation of Viable Research Designs

When there is a qualitative difference with respect to behaviors and quality of life, then a qualitative method may need to be employed, such as when dealing with patients who display traumagenic compulsions (Berg, 2007; Berrios & Lucca, 2006; Bordens & Abbott, 2005; Neuman, 2006; Sproull, 2002; Weinbach & Grinnell, 2007). Golafshani (2003) noted that researchers may need to experience the feel of the behaviors in order to describe them. If this is the case, then interventions and treatments may be studied using qualitative research first, before the quantitative methodology is employed (Golafshani, 2003). In addition to these assertions, Berrios and Lucca (2006) defend the use of real life qualitative methods for the social sciences in real life applications rather than experimental lab research. Further, qualitative methods delineate subtle differences in perceptions and hermeneutics, whereas quantitative research may miss those differences.

Accordingly, Granello and Wheaton (2004) offered strategies for data collection that could be employed with clinicians or with the general public in this regard. Therefore, a focus group interview for therapists or an online survey may be a viable data collection strategy if needed as a secondary process. Either methodology could occur after this study for future research to reveal what the general consensus of therapists is regarding the link between childhood sexual abuse and the subsequent development of

compulsive collecting or compulsive hoarding. For now, this topic is noted herein in case it comes up in the interviews for this study.

The absence of literature specifically dealing with the treatment protocols for people with traumagenic compulsions is noted by Hartl et al. (2005). The review of the literature above is intended to set the research modality for a qualitative research study. The study would include obtaining data of seasoned clinicians who have successfully reduced traumagenic compulsions, and this study would also be providing direction for future research. The fact that people with traumagenic compulsions are a highly vulnerable population is evident. As such, the likelihood of following research of the patients themselves is not feasible. Furthermore, with both a scarcity of time and money, the direction of qualitative research seems obvious.

Leedy and Ormrod (2005) recommended one viable research design as a comparison of groups with different conditions of treatment. The treatment group could receive the same combination of cognitive behavior therapy and traumagenic resolution modalities. However, the control group could receive no treatment and could receive observation only for the same period of time as the treatment group. The design described has been called a quantitative observational design (Leedy & Ormrod, 2005). After the period of time had elapsed and comparisons were made, the control group could receive treatment. The compulsive behaviors or the childhood sexual abuse issues could then be addressed until desired outcomes were obtained. The null hypothesis could state that there would be no difference in treatment with evidence-based outcomes between the treatment group and the control group. The glaring weakness with this research design is the ethical problem of withholding treatment from individuals who may be in need.

Withholding treatment from any group, at any time, for any duration of time, is not advisable, yet it has been done, as shown within the literature cited and references. The strength in this research design is that there would be no threat to internal validity, since there is clearly a treatment and group which does not receive treatment (Verona & Sachs-Ericsson, 2005).

Although similar research designs possess both strengths and weaknesses, Leff (2005) found that innovations in behavioral healthcare services are present throughout the lifecycle of the organization. When innovations are sought after, evidence-based practices (EBPs) will emerge in an organic fashion of the system. Living systems produce living innovations, and the evidence-based practices (EBPs), such as initiation and implementation, are a vital life force in an organization. Leff noted that seasoned clinicians often rely on initiation and implementation of various techniques while working with patients.

Just as organizations and clinicians continually seek innovations in treatment methods, researchers seek innovations in research methods. Mertens (2005) wrote that the logical positivism of quantitative research is a means of knowing what is known and understanding why the need to know it. However, in comparison to phenomenology, humans do not really need to know the why, nor can the why really be known (Mertens). It is interesting that in cognitive behavior therapy, clinicians steer people away from asking similar questions, and in the classroom, teachers profess the humility that students cannot really answer the question why. After all, researchers cannot explain anything; they can only describe what is observed. Researchers can label and can relate what is labeled to their experiences (Mertens). As soon as alternate experiences enter in,

observers acknowledge the need to change the label. Likewise, the framework of constructionism captures the essence of the finding in qualitative research (Mertens). Community interventions reduce the risk of child maltreatment by changing community beliefs and accomplishing fear reduction. Also, interpretive social science as a means of constructivism is the desired direction in obtaining emerging information to fill scientific gaps. In the same manner, the discussion of evaluating other designs is settled when realizing the importance of studying the data collected by seasoned clinicians who are treating people with traumagenic compulsions (Crosson-Tower, 2005). These clinicians, who are bringing about relief for patients who have been suffering for most of their lives, deserve to be heard so many others may experience relief as well.

Another topic that may emerge from the interviews is how community interventions and clinicians' treatments evolve with research and with successes; however, there are still individuals who are overlooked within the systems. Some clinicians may see gender differences at work in the way they treat the patients. Paludi (1998) contended that when women want to bring about positive change, they do not receive the community support necessary to bring about the change. Therefore, women and their children seem to be trapped in systems that will not assist them to change (Paludi). Women are in a position to do the most good in preventing child maltreatment. In order to facilitate these preventions, Paludi pointed out that cognitive readjustment of beliefs needs to include coping, learning, adapting, self-confidence, honesty, and strength. There seems to be a way to teach people relational intimacy with self, in order to succeed in changing old cognitions into cognitive corrections (Paludi). Specifically, the cognitive distortions, including magnification of the negative, imperatives, all-or-

nothing thinking, mind reading, and negative forecasting, need a modality to cease in order to be replaced with cognitive corrections and may need to be accomplished uniquely in women than in men (Paludi). Paludi stated that clinicians who do not consider these facets of treatment may have lower rates of accomplishing the stated outcomes than clinicians who do factor in these facets of treatment.

Frost, Steketee, and Greene (2003) noted that the literature reviewed stated that the presence of traumagenic compulsions is generally defined as having the components of a multifaceted problem. Problems include information procession, attachment with strong beliefs pertinent to saving possessions, avoidance of distress associated with discarding possessions, difficulty making decisions about possessions, and the presence of excessive acquisitions (du Toit et al., 2001; Frost, Steketee, & Greene, 2003; Lochner et al., 2002; Lochner et al., 2005). According to their definition of the problem, these researchers conclude compulsive collecting is not life-threatening whereas compulsive hoarding is life-threatening.

Frost, Steketee, and Greene (2003) clarified that while cognitive behavior therapy is an effective means of treatment in some cases, symptom substitution can occur in other cases. Further, in a landmark study, Greenough, Black, and Wallace (1987) demonstrated how negative experiences adversely affected brain development in children and may lead to symptom substitution rather than symptom reduction. As a result of this negative impact upon brain development, the ability of children to control negative behaviors was greatly reduced. Hartl et al. (2005) noted that the participants, who did not respond to treatment in the reduction of compulsive behaviors in previous research studies on traditional cognitive behavior therapy, may have a history of child abuse or neglect. If

that is the case, the added negative outcomes from a research study may actually increase the symptoms of these individuals. Although their behaviors may appear to be similar, clearly, treatment techniques for patients with a history of childhood abuse or neglect need to be different from those who do not have a history of childhood abuse or neglect (Hartl et al.).

du Toit, van Kradenburg, Niehaus, and Stein (2001) highlighted the extreme difficulties in collecting data from persons who have endured childhood traumas. Similarly, Jacob and Veach (2005) noted the difficulties in working with persons of childhood sexual abuse (CSA) and their families. If time and funding permitted, it may be most advantageous to use an investigative interview technique of persons with sexual abuse histories, much like the structured interviews used in Verona and Sachs-Ericsson (2005); du Toit et al. (2001); Lochner et al. (2002); and Lochner et al. (2005). This type of progressive questioning could start with the data from participants using the CDC (2006a) Adverse Childhood Experiences (ACE) study: The Family Health History and Health Appraisal Questionnaires (FHHHAQ). The CDC (2006b) developed this measure as a starting point, or benchmark, for qualitative as well as quantitative use. In this manner, the research would need to occur to compare treatment protocols for patients, because some patients may have the same symptoms but different etiologies. An example of this would be traumagenic compulsions caused by childhood sexual abuse versus compulsions due to other reasons, such as organic etiologies or learning histories.

Related to this need for future study to develop treatment protocols, Hartl et al. (2005) found that the study of treatment outcomes in the reduction of traumagenic compulsions is needed in the population of those who have a history of childhood sexual

abuse. This study would accomplish this by interviewing seasoned clinicians who have a history of positive outcomes in reducing traumagenic compulsions in patients of all ages. Berg (2007) discussed the basic rules for interviewing and for conducting the interview in person. However, several online data collection engines are available for the same purpose. Some even accomplish in-depth interviewing (Itracks, 2006; SurveyMonkey, 2006). A quandary exists concerning the most efficacious technologic methodology to employ for qualitative behavioral research questions (Merriam, 2002). Leff (2005) and Thomas (2003) described a need of behavioral science as wanting access to information that is the most useful to the greatest number of clinicians, for the greatest good of the most patients. The use of technology would help both in the data collection and in qualitative data analysis.

As one of the means to use technology by data collecting and analyzing qualitative data, the ladder approach by Price (2002) is divided into three sections. The first asks questions about action, second contains questions about knowledge, and thirdly inquires about the person's underpinning philosophy/feelings/beliefs/values of the answers. Telephone interviews of seasoned clinicians would seem to be the most efficacious methodology for this study. A ladder approach of writing and ordering the questions, as demonstrated by Price, would most likely yield accurate qualitative results. The questions and answers for the telephone interview are to be recorded, transcribed, and are to be analyzed with qualitative analyses. This interview process would employ the Rapid Assessment Process techniques of qualitative research, according to Beebe (2002), to find data pertinent to human service clinicians.

These interview methods of utilizing technology to most efficiently collect and to analyze data can assist clinicians greatly but should benefit the patient above all. von Bertalanffy (1968) emphasized the systems that are present and in need of balance whenever complex changes are attempted in individuals within a community context. In order to maintain these delicate balances, Vygotsky (1978) voiced caution to clinicians and educators alike in delineating attempts to produce change in people with abrupt techniques. Whether attempting to produce changes in people, in research, or within a discipline, change needs to proceed slowly and cautiously for the sake of all involved. Wadsworth (1998) and Wellner (2003) offered the paradigm of participatory action research. Likewise, this study was intended to bridge needed changes in people, in research, or within a discipline, in a gradual manner.

The literature is relatively scant in connecting compulsive behaviors to childhood sexual abuse. Researchers have not probed into the views of clinicians on this matter as noted by Hartl, Duffany, Allen, Steketee, and Frost (2005). Most clinicians working with patients who display traumagenic compulsions have not queried into any childhood sexual abuse history as stated by Hartl et al. (2005). Accordingly, Hill, Thompson, and Williams (1997) stated that the guide for conducting consensual qualitative research is *a priori* to a lack of demonstrable research. Schulze (2003) and Sidman (1960) pointed out that all research is conducted in steps, proceeding from the unknown to the known. A lack of research may be the precise place to start (Glickens, 2003; Sproull, 2002). Tebes (2005) noted that community science emerges from an inductive philosophy of science, and that the practice of research is to methodologically answer questions, either in one setting or in many settings, moving from a small sample to a larger sample. While there

are some who would argue that qualitative research is not a viable methodology, Tebes documented the use of qualitative methods in community science as a preferred framework for topics involving community science, such as the one herein.

Becker (1998) and Glatthorn and Joyner (2005) stated they have employed the methods and with qualitatively reliable and qualitatively valid results. Beebe (2002) encouraged the use of Rapid Assessment Process (RAP and Mini-RAP) for *qualitative* research where there are no present findings, and the field would benefit from these findings. Rapid Assessment Process (RAP) can be used when investigating various complicated situations; (a) when issues are not well defined, and (b) when there is neither time nor other resources for long-term, traditional quantitative or qualitative research.

Hartl et al. (2005) pointed out that an attachment disorder is at work concerning patients with traumagenic compulsions. Accordingly, the theory and applications of the most promising attachment disorder treatment as an example of one type of traumagenic resolution therapy can be utilized. The outcomes of Prolonged Parent-Child Embrace (PPCE) Therapy by Welch, Northrup, Welch-Horan, Ludwig, Austin, and Jacobson (2005) discussed a means to treat child disorders to greatly reduce child maltreatment in America. PPCE Therapy can be very promising by helping both children and the adults to regulate stress (Welch et al.). It may be an expressive, effective treatment which can combine cognitive behavior therapy and traumagenic resolution therapy. Welch et al. noted that resilience is promoted in PPCE, as the child can repeatedly express the stories of abuse and neglect while receiving comfort at the same time. As a result, the parental oral assessments verified the reduction of behavioral problems. This was true for all 102 children within a 1 year follow-up as reported by phone. Of equal importance, at

baseline, 48 of the 102 children were on 75 prescriptions for 20 different pharmaceutical agents. However, at the end of one year, the parents of 96 children reported by phone interview, and fourteen of these children were on 18 prescriptions for six different agents. It appears that children would benefit from more holding time. Holding time as described by Welch et al. is a positive stress-response regulating cycle that teaching children to relax internally without the need of externalizing behaviors like compulsive collecting or compulsive hoarding.

Summary

The constructs which the seasoned clinicians may use are purposeful and effectual. The dialectic of talking about both the negative trauma and positive events in the child's life appears to bring hope and healing to all. The importance of balanced family narratives is paramount (Crosson-Tower, 2002). Either extreme of ignoring the trauma or ignoring good times seems to increase pain in the child's life and in later life. Further, life seen as a panoramic view and story implies that both must be told again and again.

Crosson-Tower (2002) stated that perhaps more child abuse and neglect advocates are needed. The author noted that the motto of an advocate at speaking engagements, pageants, and conferences is "From Victim to Victor," inspired by the abuse war stories which turn desperation to hope. Crosson-Tower also noted that an advocate motivates others by reminding them that "failure is an event, not a person." It is difficult to lead a victim to believe this type of statement, but a victor will believe it. Additionally, Baarnhielm (2004) offered a restructuring paradigm for clinicians to use with patients

that will bring balance to the lives of the patients. The terms offered by Baarnhielm will assist in the formation of constructs to analyze in the data collected in the research study.

In the field of human services when advocacy is involved, the battles and wars to bring about positive change are not won alone, according to Baarnhielm (2004). Yet that is what many expect of the child victim of the abuse/neglect war. In addition, many clinicians often work in isolation of other clinicians who are treating people with the same etiologies and disorders. One such group is adult rape patients who were also raped as children. Both abuses are horrific, yet the patients have stated it is more difficult to resolve being raped as a child than as an adult. The message, "It is your fault," is loudly heard in both cases. What patients need to hear from many people in many ways and many times is, "It was not your fault." The guilt, shame, and rage can only be relinquished when a coalition of people assist the victims. Hence, the attachments to things in emotional ways make sense to them. Then, the victim eventually can win the cognitive battles and the war to become a victor (Crosson-Tower, 2002). Furthermore, victors need to tell their stories over and over again to bring about positive, lasting community change. Another term Baarnhielm (2004) gave to the patients who have overcome past horrors with resilience and strength is that of a thriver. In the stages of healing, the patient moves from victim, to survivor, to thriver.

Conversely, Crosson-Tower (2002) showed how silence clearly perpetuates the problem of child abuse and neglect. The author noted that whether discussing community silence about the abuse or the silence clinicians maintain in keeping confidentiality, breaking the silence with hope can bring about some of the change desperately needed. In particular, Crosson-Tower (2002) wrote that understanding the framework of

victimization could help make the connection as to why emotional attachment is made to possessions as a result of one's virginity being taken by force at a young age. However, the use of implosion should never enter the mind of the clinician who is treating such a vulnerable patient.

Although such methods can be harmful to patients, helpful means are also available. Merriam (2002) clearly delineated the need to hear the voices of people who bring about positive change in others. By extrapolating the findings of Merriam to the study of clinicians who treat traumagenic compulsions, the data obtained can direct future research from a framework of constructionism. The recommendation would be to conduct basic interpretive, qualitative research in discovering, understanding, and interpreting the clinicians' perceptions (Baarnhielm, 2004; Golafshani, 2003; Merriam, 2002). The philosophical foundation for basic interpretive qualitative research is constructionism (Merriam, 2002). According to Merriam (2002), constructionism is widely used in social sciences and education research.

Within the same foundation of constructionism, various studies reveal further effective means of treatment. Using data from over 60 studies, Pope and Brown (1998) stated that humans can behave in a way that demonstrates a trauma occurred, and yet the trauma may not be clearly recalled. Also, trauma memory and recall is reliable, even though slight distortions may exist. Behavior is more indicative of an event occurring than the recall may imply. A person can say that an event in the past does not currently affect them, while the behaviors indicate that the event does presently affect him. Further, many behaviors are learned within the first years of life; the exact means of learning may not be recalled, but the learning may be indicated through behavior.

Just as behavior may indicate past experiences, behavior may indicate the needs and imbalances a patient has experienced during development. Joachim, Lyon, and Farrell (2003) cited a theoretical construct as Antonovsky's sense of coherence theory, postulating that one maintains behavior to achieve balance and coherence in life. Joachim, Lyon, and Farrell (2003) found that traumagenic compulsions may become life-threatening, and the purpose which is achieved by the behaviors needs to be explored before the behaviors can be reduced. Thus, treatment needs to go beyond what most modalities provide, facilitating a person to find avenues to achieve coherence through behaviors which are not compulsive (Joachim, Lyon, & Farrell).

Together, the theories noted heretofore provided the interpretive phenomenological light for the analyses of the responses that the clinicians gave in the interviews. Sidman (1960) stated

But the rare discoveries are usually built upon a foundation of small findings, none of them world-shaking in themselves, without which the final step could never have been taken. A major concern of science is the soundness of the basic edifice. (p. 33)

Sproull (2002) noted that the constructionism theoretical framework of a qualitative study also conveys an effort of interpretivism that seeks to identify, understand, describe, and maintain the subjective experiences of the respondents. Further, Oyama (1985) stated that research built upon observations that interpret the data while still unfolding is research that is more realistic. Thus, the literature demonstrates a need for theory and application on the topic of reducing traumagenic compulsions in patients with a history of childhood sexual abuse. Further, as with other disorders noted by Oyama, this is another reason that demonstrates the need in distinguishing between and treating subsequent symptoms of

compulsive collecting and compulsive hoarding due to variant etiologies. Oyama contended that obtaining extensive developmental histories is crucial in treating any disorder.

As a review of the goals of this research were to first shed light on how seasoned clinicians assess and treat traumagenic compulsions in those patients who have a history of childhood sexual abuse. The second goal was to identify the most significant obstacles or resistance in treating those patients who have a history of childhood sexual abuse and who also compulsively collect and hoard. The third goal was to obtain the clinicians' experiences and narratives on how both CBT and traumagenic resolution therapy helps those patients who have a history of childhood sexual abuse and who also compulsive collect or compulsively hoard.

As noted by Merriam (2002), often in qualitative studies, the research design follows a specific model. As defined by Guba and Lincoln (1989), this research design sought to discover and to understand perceptions and constructions. The conceptual argument elucidating the research was to guide future research that is called for in helping patients with traumagenic compulsions and a history of childhood sexual abuse. Thomas (2003) provided content analysis programs available for the types of verbal responses obtained in interview data. As described by Merriam (2002), content analysis lends itself easily to constructionism.

CHAPTER 3. METHODOLOGY

Research Design

As noted earlier, the literature is relatively scant in connecting compulsive collecting and compulsive hoarding to childhood sexual abuse. Hill, Thompson, and Williams (1997) stated that the guide for conducting consensual qualitative research is *a priori* to a lack of demonstrable research. Likewise, Schulze (2003) and Sidman (1960) pointed out that all research is conducted in steps proceeding from the unknown to the known. Also, Sproull (2002) and Tebes (2005) noted that community science emerges from an inductive philosophy of science. These authors contend that the practice of research methodologically answers questions either in one setting or in many settings, from a small sample to a larger sample.

More specifically, there is also very little literature on the treatment of patients who compulsively collect or compulsively hoard and who have a history of childhood sexual abuse. How clinicians reduce traumagenic compulsive behaviors in patients who have a history of childhood sexual abuse was the basis for this research. Guba and Lincoln (1989) note that constructions emerge from experience and interactions within contexts. In this context, seasoned clinicians possess constructions that can be studied to produce treatment protocols. Guba and Lincoln found that qualitative research, or the fourth generation evaluation paradigm, provide data within lived experiences as a methodology of phenomenology. Similarly, Moustakas (1994) stated that

phenomenology is the first method of knowledge as the beginning of things themselves. Moustakas also argued that phenomenology is the final court of appeal for knowing, since its methodology attempts to eliminate prejudice and presuppositions while examining things with freshness and openness.

Treatment, according to Polanyi (1967), needs to contain constructs that assist change, including talking about love as a type of traumagenic resolution therapy. It was hoped that the seasoned clinicians may shed some light on this construct. The interview questions do leave some room for that possibility per Price (2002). Polanyi asserted that people change by saying that change will occur and that is among several favorable treatment constructs to seek out. Polanyi demonstrated that individuals grow from self-centeredness towards other-centeredness when love is present. Conversely, the author states when love is absent, self-centeredness is difficult to grow out of. Polanyi (1967) and Seligman (2006) stated that human growth and development of self occurs as individuals say the growth is to occur within the phenomenological perspective (Sproull, 2002). There is a difference between phenomenology with the philosophical orientation of hermeneutics. Change in hermeneutics is gradual, whereas change in phenomenology is sudden (Sproull). The unfolding of complicated behaviors in patients hinges on the words used in the process of change (Polanyi, 1967; Seligman, 2006).

While the rate of change varies between individuals and by methods utilized, seasoned clinicians have helped patients reduce traumagenic compulsions by combining theories and treatments without a set of established practice guidelines (Hartl et al., 2005). Many times, positive outcomes in treatment have been obtained by trial and error or from personal experiences. The views of these seasoned clinicians need to be gathered

to begin a different set of treatment protocols. Beebe (2002) emphasizes attention to detail in gathering these views with a qualitative research design. As Beebe noted, one purpose of research serves to fill the gap with clinicians who help patients reduce traumagenic compulsive behaviors with an intervention or treatment that combines cognitive behavior therapy with traumagenic resolution therapy (Joachim, Lyon, & Farrell, 2003).

This researcher's philosophy, as stated in Creswell (2003) and Mertens (2005), was the philosophical foundations for qualitative research that are rooted in naturalism, interpretism, constructionism, and/or critical research. The personal philosophy and foundational philosophy are derived from (a) the ontological assumptions, or the view of the nature of reality, which includes multiple realities that are socially constructed by individuals, (b) the epistemological assumptions, or the view of knowledge that involves the acquisition and transmission of the understanding and meaning through experience, (c) the axiological assumptions, or herein the view of the role of values that are highly relevant and based on the researcher's subjective values, intuition, and biases, and (d) the methodological assumptions or research strategies that fit best with problem and research question in a qualitative study as noted herein.

Additionally, there are four key assumptions in the process of research (Crotty, 2005). For this qualitative study, the four key assumptions are as follows. First, there are ontological assumptions about the nature of reality and the characteristics of the social phenomenon. Hartl et al. (2005) emphasized the role of emotional attachment to possessions as a way to examine the best treatments and evidence-based practices for the treatment of compulsive collecting and compulsive hoarding due to childhood sexual

abuse. Also, Antonovsky's sense of coherence theory postulates one maintains behavior to achieve balance and coherence in life (as cited in Joachim, Lyon, & Farrell, 2003) and was valuable for the study at hand. Second, there are epistemological assumptions in the acquisition of knowledge. In this study, constructionism was the guiding theory of research. According to Merriam (2002), constructionism is the meaning and purpose given to phenomena. Third, there are axiological assumptions that describe the role of values and the role of objectivity/subjectivity in research. Beebe (2002) described the process used in this study as Rapid Assessment Process. Sproull (2002) recommended that the findings of qualitative studies are to be presented in a framework, providing objective and subjective credibility, transferability, dependability, and confirmability. Fourth, there are methodological assumptions that are specific research strategies in accumulating scientific knowledge, which, for this study, would be the process of questions in interviews as a qualitative process. Price (2002) provided the framework of ladder questions for the process and direction of the questioning. Price found that meaning emerges through the experience of the interviews. In this study, the interviews are with clinicians who treat patients with traumagenic compulsions and a history of childhood sexual abuse.

The research design model used ladder questions in a telephone open-ended structured interview in an attempt to answer the following research questions:

1. How do clinicians assess and treat traumagenic compulsions in patients who have a history of childhood sexual abuse?

2. How do clinicians describe positive and negative outcomes in treatments of patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard?

3. What are the most significant obstacles or resistance in treating patients who have a history of childhood sexual abuse and who compulsive collect or compulsively hoard?

According to Price (2002), the phone interview typically consists of laddered questions when used in qualitative phenomenological research design. The research design herein used laddered questions in a telephone open-ended structured interview. Since this was to be a national response, and a relatively small population, the telephone structured 'interview and record' process was employed. Although the participants were all from the same region, it was unknown at the outset whether enough regional participants would be available, and it was important to be consistent with all interviews, so telephone interviews were used for all participants regardless of location. The laddered approach first asked questions about actions, then contained questions about knowledge, and finally presented questions about philosophy, feelings, beliefs, and values. The data analysis consisted of the transcribed responses of the seasoned clinicians to the open-ended questions and submitted electronically for data analysis using the Ethnograph software. The researcher asked interview questions of the clinician participants over the telephone, while the answers were transcribed and then analyzed in the course of one hour or less per clinician. There was careful attention exercised in the interview process, using techniques such as extended conversations, offered by Sproull (2005). Sproull also noted that the first phase of data analysis is to code the responses in patterns and then

integrate, build, and emerge themes towards a theory. According to Sproull, the thorough analysis of data in phases is essential to comprehend the data of participants while allowing the theory to emerge.

Sample

A general call for participation via e-mail with criteria went out first to three of the four associations. The American Counseling Association was not contacted as the desired number of 10 participants was obtained from the other three associations; the American Psychotherapy Association, the American Counseling Association – Missouri, and the Missouri Mental Health Counselors Association. As the clinicians who met criteria responded to the call for participation, the interviews were set up. The phenomenological approach was employed to determine if child abuse and neglect produce compulsive behaviors that are resistant to any type of implosion treatment. An additional concept and corollary offered by Seidman (2006) was the type of purposeful sampling that was employed with a wide range of selection within the criteria parameters. Purposeful sampling (Seidman) was described as the combination of experiential and researched components of a participant in a qualitative study.

This research used a phenomenological framework to explore how clinicians use a combination of cognitive behavior therapy (CBT) and traumagenic resolution therapy (TRT) to treat traumagenic behaviors in patients who have a history of childhood sexual abuse (Joachim, Lyon, & Farrell, 2003). The selected criteria of the participants were noted. The Conditional IRB approval from the associations as a call for research

participation was obtained. The selected criteria were the rationale for the sampling in that the descriptors below and also described the experience of the primary researcher.

1. Is a member of American Psychotherapy Association, American Counseling Association, American Counseling Association – Missouri, or the Missouri Mental Health Counselors Association.

2. Has been a licensed clinical practitioner for a minimum of 15 years, have treated children, adolescent, adult, or geriatric cases of traumagenic compulsions.

3. Has been trained in and uses a combination of cognitive behavior therapy (CBT) and traumagenic resolution therapy (TRT) as treatment protocol for this specific population.

4. Is presently accepting referrals of patients with traumagenic compulsions due to childhood sexual abuse (the referents' ages may vary according to specialty or any age if general practice).

The purposive sampling of people who meet the above criteria provided the data to accomplish the goals in the research. The e-mailed recruiting sampling strategy enlisted the clinicians as volunteer participants, matching them with the criteria that were noted earlier. A cascading effect of progressive e-mails to others then ensued. The selection of the participants was based on the criteria previously listed. Informed consent was obtained as the seasoned clinicians who answered the e-mailed call for research participation from the organization/associations as noted. The backup plan was that if not enough seasoned clinicians did not emerge using the approach delineated above, then a plea for seasoned clinicians was to be made to the purchased e-mail list from the

American Counseling Association(ACA). Since the ACA list was not needed, it was not purchased. There were enough participants from seasoned clinicians in the other three associations, who responded and who fit the clinical and associational criteria.

The sampling strategy employed was based upon the experience of the primary researcher and as noted in the literature review. As a movement emerges, such as the one that has emerged to help these patients, a phenomenological “handprint” emerges (Polanyi, 1967). In attempts to capture the handprint, both the viable research and the combined experiences of the people being questioned needs to be given a voice to be heard. Cultural change emerges slowly and research can record the change as a part of research (Oyama, 1985; Sproull, 2002). As a member of the associations chosen for inclusion in this study, and as a participant in the cultural change for clinicians to use evidence-based treatment approaches for people with CSA and PTSD, the opinions and phenomenological voices of clinicians have been collected at various conferences attended by the primary researcher and as read in the literature as considerations for future study. This accomplished the role of purposeful sampling and the role of the researcher (Sproull) in the combination of experiential and researched components of a researcher as participant and the other participants in a qualitative study. Since, the literature is lacking for evidence-based treatment approaches for people with CSA and PTSD, the first step recommended in this study emerged into the next step for future research to be done, and that is to develop a treatment protocol. Hence, the various questions, sampling strategies, and criteria for this study have emerged from those combined experiences.

Referring to the group of ten seasoned clinicians, to help patients reduce traumagenic compulsions, Hartl et al. (2005) noted that an established research protocol of treatment is required but does not exist at this time. According to Polanyi (1967), change is experienced in developmental increments in the phenomenological perspective of human development. Polanyi used the word 'love' in developmental constructs and stated that people grow towards love, but implodes in the face of child abuse and neglect. Thus, this research bridged the gap between practice and research.

Instrumentation/Measures

The telephone interview of open-ended questions employed the Rapid Assessment Process of qualitative research (Beebe, 2002). The Rapid Assessment Process is a means of exploring a situation when there is insufficient information or literature on a topic. According to Beebe, it is necessary to use in an area where information is greatly needed but also where research may be lacking. The process is employed where a detailed view is needed on individuals being studied in a context or natural setting. The researcher is a partner instead of an 'expert' according to Beebe in the Rapid Assessment Process. The questions for the structured telephone interview are a distillation and rewording of questions in the recommendation for future studies of much the cited literature herein using Moustakas (1994) and Sproull (2002) as a guideline. Further, the questions were written with the experiences of those being studied in mind and were discussed (field tested) with professionals at conferences where the primary researcher was a presenter and colleague.

The questions were arranged in a ladder approach of questions to be used in qualitative phenomenological studies (Price, 2002). The ladder approach first asks questions about action, then contains questions about knowledge, and finally presents the questions about the underpinning philosophy/feelings/beliefs and values of the answers. This is noted in the structured interview instrument in Appendix A.

The purpose of this qualitative study was to analyze that data of clinicians who have been treating patients with traumagenic compulsions and a history of childhood sexual abuse. In qualitative research, data obtained is often referred to as views, or voices, of the respondents (Sproull, 2002). This research study intended to explore the views, or voices, of clinicians who are using a combination of cognitive behavior therapy and traumagenic resolution therapy in reducing traumagenic compulsive behaviors.

Data Collection Procedures

The associations listed in the criteria were asked via e-mail for a “Conditional IRB Approval” in writing. The associational responses were noted in notes and were noted in the IRB Application process. Once approved, the call to research was sent via e-mail to three of the four associations who had agreed to do so, and then they sent out an e-mailed call for participation to the members of the associations by the associations. The Informed Consent Form was sent to those seasoned clinicians/ participants who responded to the call along with an invitation to view the IRB, if so desired. Once the signed Informed Consent was obtained via e-mail, fax, or using hard-copy with postage at the participants’ choice/expense, a time was arranged for the structured telephone

interview via e-mail. The signed Informed Consent Form was to be used to confirm consent verbally, by going over the consent form, at the start of the telephone interview.

Then the seasoned clinicians were asked a series of questions in a structured telephone interview to illuminate their views about childhood sexual abuse, compulsive collecting, and compulsive hoarding. According to Sproull (2002), arranging the responses as data proceeded with profiling the themes was essential to the process of studying the emerging themes. This arrangement was accomplished in the study. The structured telephone interview took less than an hour.

With the participants' awareness, the interviews were recorded via telephone. It was projected that at least 10 clinicians nationally would respond. A regional sample emerged as nine of the 10 clinicians were from one state, the state of Missouri, and the other one was from Washington state. The recruiting letter with attachments was sent. The recordings were transcribed and the data coded and entered into the Ethnograph qualitative data analysis software. The study consisted of the ten clinicians who met criteria and when the narratives were obtained, provided a comprehensive, though regional picture of treatment modalities for examination.

The clinicians were interviewed via telephone with open-ended questions. The interviews were recorded and transcribed. The recording device was a digital recording device that was attached to the laptop in order to use Skype. Oral permission for the recording while verifying the written permission was obtained prior to the questions and answers time. The questions and answers time proceeded and was recorded. A transcriptionist was employed, pledging confidentiality via a signed form per industry

standards, and typed the narratives that were analyzed. The typed data in electronic format was the data to be analyzed.

Thomas (2003) provided a method to analyze data from an ethnographic or interview program. The Ethnograph v5.0 (Qualis Research Associates, 2006) was utilized for the data analysis of the clinicians' responses submitted. As one of the means to use technology by data collecting and analyzing qualitative data, the laddered approach by Price (2002) is divided into three sections. The first section asked questions about action, the second section contained questions about knowledge, and the third section inquired about the person's underpinning philosophy, feelings, beliefs, and values of the answers. The most efficacious methodology for this study was with telephone interviews in asking laddered questions that yielded accurate qualitative results, as according to Price (2002). This is seen in the instrument in Appendix A. The questions and answers for the Telephone Interview were recorded, transcribed, and analyzed with qualitative analyses. This interview process employed the Rapid Assessment Process techniques of qualitative research, according to Beebe (2002), to find data pertinent to human service clinicians. The codes were assigned to the clinicians using last name initial only. The consent forms were stored in a separate file from the transcriptions by the researcher once all information was obtained.

Data Analysis

Granello and Wheaton (2004) offered strategies for data collection that were employed with clinicians or with the general public in this regard, as noted within the questions' design. The Ethnograph v5.0 (Qualis Research Associates, 2006) was used to

analyze the content of the submitted data. Once the data was analyzed, a flowchart and conceptual diagram emerged indicating the patterns of treatments the regional response of seasoned clinicians used in treating people with CSA and PTSD. This phenomenological approach of a qualitative study seems to convey more compassion for those suffering as those who are well (Stuart, Parker, & Rogers, 2003). The three purposes for using an inductive, qualitative approach are (a) to condense extensive and varied raw text data into brief summaries, (b) to establish clear links between the research objectives and findings, and (c) to develop a model or underlying theory descriptive of experiences or processes (Thomas, 2003). The analysis will keep in mind that Sproull past tense(2002) recommended that the findings of qualitative studies are to be presented in a framework, providing objective and subjective credibility, transferability, dependability, and confirmability.

While qualitative data collection methods may result in more meaningful data than quantitative collection methods, the additional benefit may only be attained if the researcher is able to effectively manage all facets of the data collection process. However, questionnaire and data interpretation may also be subject to researcher bias (Sproull, 2002). The participants' narrative was subject to selective perception and recalled experiences that may not always provide an accurate or complete account of actual events. There is the possibility that the study data may still be improperly coded or interpreted, resulting in flawed conclusions. Further, the study was more of a regional study rather than a national study.

Qualitative research is of a nature that the findings emerge during the study. The researcher made every attempt to set aside preconceptions of results. The views of the

clinicians were reported to allow the real meaning of their experiences to be revealed. Despite the emergent nature of this study, it is possible to anticipate some general findings based on what others have found. With this in mind, a reminder by Stuart, Parker, and Rogers (2003) is again noted that the phenomenological approach of a qualitative study seems to convey more compassion for those suffering and clearly the patients are suffering while being compassionately treated by the interviewed clinicians.

Ethical Considerations

The seasoned clinicians, as study participants, were selected following the steps outlined in the sampling design. Prospective participants were encouraged to ask questions and to express concerns about the study and their role with the researcher as noted in the Informed Consent Form, and as also directed by Moustakas (1994). This encouragement can be offered in what Moustakas wrote regarding social conversation to bring about a relaxed atmosphere of trust at the start of any phenomenological interview. Informed consent to participate in the study was obtained from all participants in writing as noted. Appropriate precautions were taken at all phases of the study to protect the privacy of the participants and to maintain the confidentiality of data. These precautions included using codes to mask the identities of the participants and their employers. All identifying information was removed from the data in the electronic and paper formats and codes were issued using last name initial only once all the information was obtained. After the transcription and analyses, the data will be shredded using McAfee electronic shredding protocol seven years after the data was obtained.

The three overarching principles of ethical research-(a) respect for persons, (b) beneficence, and (c) justice (Capella University, 2006) are crucial for all research involving humans. Further, the USHHS (2005) Code of Federal Regulations requires documentation to this case prior to the research filed with a schools' or organizations' IRB (Institutional Review Board) who reviews all research affiliated with the institution. Jacob and Veach (2005) noted the difficulties in working with people around the topics of CSA and PTSD. Specifically, it is a difficult topic for patients and clinicians to deal with in the therapeutic milieu. In addition, families that deal with the deleterious effects within the family system have difficulties even when the perpetrators are not within the family system. Additionally, Jacob and Veach noted the endemic problem in researching or treating CSA survivors in that there is a higher tendency towards litigious actions on their behalf.

Even though the seasoned clinicians were interviewed in this study, the results of the findings need to be presented and published so that (a) respect for persons, (b) beneficence, and (c) justice are safeguarded for all; patients, clinicians, academia, and the general public. Hagen (2004) emphasized the possibility of a conflict in ethics in any research topic and the study needs to be scrutinized in advance. The approach of this study was to interview seasoned clinicians and that helps to ensure the ethical presentation of the data and thereby ethical findings. The seasoned clinicians themselves are more than likely to word the data in ethical ways based upon their experiences and in their commitment to the ethical standards of the associations. The study by Hill, Thompson, and Nutt (1997) produced consensual qualitative research that demonstrated how it is helpful to follow the associations' ethical guidelines within a study as well to

ensure that (a) respect for persons, (b) beneficence, and (c) justice are safeguarded for all. Respect is to be demonstrated in this study by the informed consent and confidentiality steps taken. Beneficence is demonstrated herein in the steps of analyses by careful scrutiny of the data and avoiding any detrimental leaps of conclusions. Every attempt was made so that the findings of this qualitative study are presented in a framework, providing objective and subjective credibility, transferability, dependability, and confirmability. Justice is and will be demonstrated by the accuracy of the reporting of the research and data obtained.

The primary researcher, as a member of each of the following associations who agreed by the ethics and principles of each association, contacted the American Psychotherapy Association, American Counseling Association, American Counseling Association of Missouri, and Missouri Mental Health Counselors Association to request permission to forward the e-mail their membership to solicit participants for this study. This study was begun upon the approval of the research proposal and after the submission approval of the Institutional Review Board (IRB) of Capella University, with the application approved with the Informed Consent which is seen on file with the IRB. Careful attention was adhered to in the regard of (a) respect for persons, (b) beneficence, and (c) justice throughout the study. In addition, the primary researcher pledged to continue to adhere to the Code of Ethics as noted within each association.

CHAPTER 4. DATA COLLECTION AND ANALYSIS

Introduction

The focus of the study was to better understand the experience of seasoned clinicians dealing with clients who had a history of childhood sexual abuse and compulsive collecting or compulsive hoarding. The purpose of this study was to determine how clinicians treat people with compulsive behaviors following traumas associated with childhood sexual abuse. As a review of the goals of this research are to first shed light on how seasoned clinicians assess and treat traumagenic compulsions in those patients who have a history of childhood sexual abuse. The second goal is to identify the most significant obstacles or resistance in treating those patients who have a history of childhood sexual abuse and who also compulsively collect and hoard. The third goal is to obtain the clinicians' experiences and narratives on how both CBT and traumagenic resolution therapy helps those patients who have a history of childhood sexual abuse and who also compulsive collect or compulsively hoard.

This study was intended to yield patterns that emerged from the responses of the structured interview of the seasoned clinicians that shed light on successful treatment methods. The study was patterned as something needed to begin to develop a protocol for this specific group of patients (Hicks & Sales, 2006). The research study explored the views, or voices, of clinicians who are using a combination of cognitive behavior therapy

and traumagenic resolution therapy in reducing traumagenic compulsive behaviors in patients with a history of childhood sexual abuse.

A call for participation e-mail was sent from the principal investigator to the associational e-mail of the American Psychotherapy Association, the American Counseling Association – Missouri, and the Missouri Mental Health Counselors Association. The e-mail was then sent to the membership from the associational officers and staff. The phone interviews were recorded with a digital voice recorder. The structured telephone interview was expected to take less than an hour, but only took 15-30 minutes. The first section of questions (Q1-3,5) in the interview asked about action and covered the first research question, the second section (Q4, 6-7) contained questions about knowledge and the second research question, and the third section (Q4, 8-13) inquired about the person's underpinning philosophy, feelings, beliefs, and values of the answers and the third research question. As noted later, some of the responses to the Interview Survey questions were used in various or several research questions depending upon the responses.

Research Questions

Sufficient data were obtained to sufficiently answer the three research questions as seen in this chapter and the next. As a review, the three research questions are: How do clinicians assess and treat traumagenic compulsions in patients who have a history of childhood sexual abuse? How do clinicians describe positive and negative outcomes in treatments of patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard? And, what are the most significant obstacles

or resistance in treating patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard?

Results

Participants

To protect the confidentiality of the respondents, very little demographic data were was obtained. Of the 10 respondents, six were women and four were men. Most were practicing in the state of Missouri, except one, who practiced in the state of Washington. The calls were set up via e-mail exchanges initiated from the participant to the researcher. The first 10 respondents were the ones who participated in the interviews and occurred within five weeks after the first call for participation went out. In other words, only those who met criteria responded and all who made initial contact and met criteria participated. The researcher did receive five other e-mails of encouragement from colleagues, who stated they would participate if they met criteria. As seen in Appendices D and E, the criteria stated in the association e-mails with the Informed Consent attached, did not query the participants for their latest degree obtained.

The Interview

Before the actual interview began, conversation was very brief and the review of the consent to record was noted. Nothing more was said so as not to be leading or directing the responses. Anything said to the participants by the researcher was only an effort to develop rapport, gather information, and to create a relaxed and trusting atmosphere as described by Moustakas (1994). The researcher reiterated the purpose of the interview and the participants were given an opportunity to voice any questions or

concerns. The nature and parameters of the informed consent form were briefly reviewed. The participants were asked to sign the consent form before the interview began and fax it to the researcher. That goal was accomplished by all of the participants. All of the participants appeared to be open, honest, and willing. The interviews averaged about 21 minutes and the recording equipment worked according to plan. Each interview was continuous with no interruptions or calls dropped. All but two participants were in the workplace when the calls took place; with the other two at home. One of the calls made to the participant's home landline had such a busy schedule; that the interview took place on a Saturday morning at 7:30 am CST. The other interviews took place during work hours during the week.

Documentation

Whenever possible, documentations were noted as to the number called to verify setting and the veracity of experience was checked. All participants were volunteers and willing to participate as indicated by the signed informed consents obtained.

Confidentiality was assured to the participants.

Ensuring Credibility

Throughout the data collection and analysis, the researcher made a concerted effort to ensure and safeguard qualitative rigor. The exact wording of the questions asked was noted in the script of the interview questions. Anything else said by the researcher, such as "OK" or "You may have answered this before, but I will need to ask the questions as scripted" was for courtesy and to let the participant know the researcher was still connected and listening.

Findings

Data Analysis

As soon as the interview was done and recorded, it was immediately converted to a .wav digital file, and then the file was sent via e-mail to the transcriptionist. The turn around time to send the transcription in a document file via e-mail back to the researcher was usually within the day. The transcribed verbatims were filed into the Ethnograph v5.0 for qualitative analysis. After reading through the verbatims at least four times, the codebook process of the Ethnograph was set to explore various words or concepts, such as time, treat, outcomes, openness, disclosure, as a type of assessment, in the research questions of the study. In the select search options, the multiple codes button was set and the identifier filters were set so the output generated would be in segments and code sequences as all the verbatims were saved in the program as files to search all files. Data procedures and code procedures were set to search for assessment as observation and testing and to profile the patients. The researcher then read through the findings and the recurring data were then noted and highlighted.

Findings for the First Research Question

First research question. How do clinicians assess and treat traumagenic compulsions in patients who have a history of childhood sexual abuse?
The first research question as obtained from the first three questions of the interview survey; Are you familiar with the terms *compulsive collecting* and *compulsive hoarding*? How do you understand *compulsive collecting* and *compulsive hoarding*? How do you understand traumagenic compulsions? and the fifth question; How do you assess

traumagenic compulsions? yielded a variety of responses that showed a use of a combination of formal assessment measures, behavioral observations, and formal interviews as articulated and elucidated by M:

We use the checklist 90 which is a screener that we use with all clients for pre and post measures on therapy to see how well they've done.

Interviewer: OK

Participant Dr M: And there's an OCD indicator, there's a set of questions in there that have OCD indicators and if those were elevated then I would probably follow up on hoarding and collecting questions if not, if they just came up in the general intake, you know with regards to the presenting problem if they said, hey look I'm hoarding things and I don't want to, or its making it really an impact on my life or driving my wife crazy, then we'd follow up and ask questions like that in there, too.

It did seem that the term obsessive compulsive disorders was preferred over the term traumagenic compulsions as stated by 10 of the 10 the seasoned clinicians. As noted in the above response, there was a clear preference of all 10 to use traumagenic resolution therapy with the patients first before cognitive behavior therapy was used.

The 10 clinicians agreed that the compulsions are precognitive and resolving the trauma first is necessary to deal with the precognitive components before the cognitive components are treated with cognitive behavior therapy. Expressive therapies were the preferred choice to use for traumagenic resolution – drawing a life map, drawing a trauma egg and tearing it apart as an expression to break free from the trauma bond are two such examples of traumagenic resolution expressive therapies to use before the attempt of cognitive behavior therapy. This was articulated by MAC who answered to Question 6:

Interviewer: OK, well tell me about your treatment strategies and you may have already covered this, I apologize for the repeat but, tell me about your treatment

strategies for those clients who engage in compulsive collecting or compulsive hoarding and who have a history of childhood sexual abuse specifically.

Participant MAC: Well, we'll talk about why they do those things, what it gives them, many times it gives them power, when, when they were abused they had no power, so they're trying to gain control in their life when they feel out of control, so we talk about other ways that are healthy techniques, that are alternate techniques that would help them through this, through these triggers.

Further the traumagenic resolution is seen by MAC also answered Question 7,

Interviewer: OK, seven of thirteen, what are the most significant obstacles in treating clients who have a history of childhood sexual abuse?

Participant MAC: The guilt and shame, often, will overwhelm them and then affect their self-esteem and how they look at themselves and how they see others, so I try to help the affirm themselves, find things about themselves that they like and that they can build upon, in other words, I look for their foundation and their experience level and work from there to build so that they can be productive and not let the abuse control them the rest of their lives.

As evidenced in the above responses, shame and guilt are treated on a broad level and beyond the mere narrow scope of cognitive behavior therapy. The way A articulated the response is below:

Participant A: The structure and even in terms of the socioeconomic factors that might help in faster recovery or in, for more sense of control and mastery, but I think that every, every event can be formative regardless of what time it occurs but especially early in life. That's when we're forming our habits and that's when we're forming our world view and if we form a world view based on trauma that is about feeling vulnerable I think that is especially likely to contribute to the development of compulsions later. The other thing I would say is that, just a second I lost my thought, is that I think that, and I'm just thinking off the top of my head is that repeated trauma would have a greater impact and would be correlated with a greater chance of developing collecting or hoarding because with repeated trauma, there's going to be more of a relapsing of negative behaviors. You know, if something is an isolated trauma that happens once, my thought, just off the top of my head, is that a person is going to be more likely to develop other coping mechanisms, other defense mechanisms, but not especially in repeated traumas, my thought would be there's some point you're just going to have to build a wall around yourself and that's where you are more at risk for doing that through collecting and hoarding.

As noted in the example of the above response, the 10 participants reported believing their patients experience a tremendous amount of pain. The pain may even seem to be an overexaggerated, overreactive response to others. But, to the person experiencing the pain, it is very real and a typical response.

As progress occurs in treatment, decompensation usually results in the patient, and due to the pain and the lack of ability of engaging in the behavior the patient wants the therapist to respond swiftly. Thus, the patient may seem to be resistant to therapy, when in fact, due to the absence of the compulsion he/she may feel like he or she is going to die and he or she does not want to die. N stated it as a “subjective fear of more sense of further trauma” as noted below. The way N articulated the response is noted in context in italics:

Participant N: Compulsions that are triggered by trauma?

Interviewer: Yes

Participant: Um I would say that I...let me formulate here for a second.

Interviewer: OK

Participant: When a person is traumatized it, their world is essentially broken apart and they start reaching for things that can be predictable, things that can be a little bit of a wall around them things that will help them avoid in, in one sense they're trying to avoid being further traumatized and so they try to build things around them and also the, the thing about objects is that objects are much more predictable than people in situations and, and things like that and so by collecting things around them and hoarding things, they're giving themselves some sense of security and some sense of predictability which helps to *lessen the at least the subjective fear of more sense of further trauma.* [Italics added]

Interviewer: OK, thank you, and how does compulsive collecting and compulsive hoarding manifest in your practice?

Participant: You know I don't have a lot of patients that to me that they are collecting or hoarding, my sense is that it, it's something that that brings a certain level of shame with it. And so I may, have clients that are engaging in that but aren't reporting it.

Findings for the Second Research Question

Second research question. How do clinicians describe positive and negative outcomes in treatments of patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard?

The second research question as noted in the overlap of responses to the Interview Survey questions four, six, and seven; How does *compulsive collecting* and *compulsive hoarding* manifest in your practice? Tell me about your treatment strategies with those clients who engage in *compulsive collecting* or *compulsive hoarding* and who have a history of childhood sexual abuse? What are the most significant obstacles in treating clients who have a history of childhood sexual abuse? and some questions in the third section as noted below; yielded a respect for patient guardedness, or a caution as a way to protect them from further harm, along with the notation that a lack of time exists to delve into the full dynamics of the issues behind the compulsive behaviors and the emotional attachment to things. Clients do not generally self-disclose the behaviors that may be producing the most discomfort and interruption in their lives.

Interviewer: OK, thank you, and how does compulsive collecting and compulsive hoarding manifest in your practice?

Participant N: You know I don't have a lot of patients that say to me that they are compulsively collecting or hoarding. My sense is that it; it's something that that brings a certain level of shame with it. And so I may have clients that are engaging in that but aren't reporting it.

Interviewer: OK, alright thank you, and tell me about your treatment strategies with those clients who may engage in compulsive collecting and compulsive hoarding and who have a history of childhood sexual abuse.

Participant D: OK, well number one I would look at the hoarding as a coping mechanism that is taking away what would almost well, re-traumatize the individual, so to acknowledge that the hoarding has served a purpose for the client and it obviously may interfere with the client's life but obviously allows the client

to continue to function however that may be, they're the client's still functioning, but then to work with the client, at his or her own pace, comfortable you know comfortable level, can't go too fast, can't go too slow to identify the trauma, and kind of approach it from a trauma treatment standpoint.

As noted in the introduction and in the literature review, the researcher had anticipated the participants would make a distinction that described compulsive collecting as non-life-threatening and compulsive hoarding as life-threatening. The distinction did not occur in any of the participants, as noted with A's response in the narrative below.

Interviewer: OK, thank you, so then tell me about your treatment strategies with those clients who may engage in compulsive collecting or compulsive hoarding and who have a history of childhood sexual abuse?

Participant A: The treatment I might engage in? Typically I'm going to engage in psycho-dynamic treatment but part of what I'm going to be doing is some cognitive restructuring but also a lot of insight oriented therapy if they're capable of insight and the goal is going to be to understand the behaviors in context and also to gain a level, you know, I believe that and there is scientific evidence that when we can verbalize something the parts of our brain involved in mastery are triggered and so we gain a level of mastery over something by verbalizing it, so its going to be real verbalizing, its going to be real oriented towards understanding in the context of history and the context how the practice develops and what purpose it serves and that's the primary intervention uh secondary intervention would be you know direct behavioral or more directive approaches but I'm only going to engage in those with low functioning clients, clients who are either intellectually unable or too guarded to engage in really too much insight therapy.

Another insight offered by A is noted below:

Interviewer: Alright, thank you, two more questions then, do you believe that childhood sexual abuse may be a contributing factor in the development of compulsive collecting and compulsive hoarding?

Participant A: To me the connection that I see is the benefit of collecting and hoarding what is, what is the purpose of that and what, what is it serving and I would say that the collecting and hoarding is serving both to help create a subjective sense of control a subjective sense of predictability in other words if I can build things around me, if I can control the things around me if I can be protected and insulated then I have a subjective sense of control and predictability.

B responded to “OK, and how do you understand traumagenic compulsions?” with “They maybe are an attempt to involuntarily contain maybe the stress and emotional difficulties related to history of sexual abuse.”

Findings for the Third Research Question

Third research question. What are the most significant obstacles or resistance in treating patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard?

The third research question findings, as noted from the overlap of responses and data to the Interview Survey questions four through 13 responses to; How does *compulsive collecting* and *compulsive hoarding* manifest in your practice? How do you assess traumagenic compulsions? Tell me about your treatment strategies with those clients who engage in *compulsive collecting* or *compulsive hoarding* and who have a history of childhood sexual abuse? What are the most significant obstacles in treating clients who have a history of childhood sexual abuse? Talk to me about the resistance in treating clients who have a history of childhood sexual abuse? What changes could you make in how you treat those clients who have a history of childhood sexual abuse? Tell me about the connection you have seen between childhood sexual abuse, *compulsive collecting*, and *compulsive hoarding*? Tell me of any changes you have seen through working with this population using cognitive behavior therapy (CBT) and traumagenic resolutions therapy (TRT). Do you believe that childhood sexual abuse may be a contributing factor in the development of *compulsive collecting* and *compulsive hoarding*? What would you like to share with other clinicians working with this

population? yielded terms like power, control, fixated, depth of pain, and lack of power. It did seem that the 10 therapists were cognizant of the resistance and guardedness of the patients in treatment. Usually, the patients are there to deal with other symptoms, and the patients generally do not volunteer their own compulsive behaviors, though there are exceptions. Thus, the patients may not want to give up the traumagenic compulsions. The narrative with Participant T noted this finding:

Interviewer: OK, thank you, how does compulsive collecting and compulsive hoarding manifest in your practice?

Participant T: About seven years ago I had a gentleman who came and admit he was a compulsive hoarder and he only came to me for a couple sessions and wanted to get to the core issue compulsive hoarding in just a few sessions and as such was his way to try to stay in control to relieve the pain.

Interviewer: OK, how do you assess traumagenic compulsions?

Participant: Generally it's possible to intuit it from the interview questions I use; I ask them about their childhood about specific in their lives, possibly parental or generational issues that might either relate generationally to these issues of hoarding and collecting and so forth.

Interviewer: OK, tell me about your treatment strategies with those clients who engage in compulsive collecting or compulsive hoarding and who have a history of childhood sexual abuse.

Participant: To attempt to have the client understand how the childhood sexual abuse hurt them in their emotional self-esteem and self-confidence and so forth and probably it is sufficient to deal with that with each client. It seems if the abuse is resolved, the compulsions cease.

MC noted how regression may develop in the course of assessment and may be an indicator of the problem and also be an obstacle:

Interviewer: OK, number four, how does compulsive collecting, and compulsive hoarding manifest in your practice?

Participant MC: I pretty much doing some assessments to detect it, but sometimes it comes up, either as the patient hoarding food or I guess anything from food to feces or other objects which indicates regression and can later deter treatment.

Interviewer: And that is the next question then number five, how do you assess for traumagenic compulsions?

Participant: Typically we use a test that works with anybody with any kind of anxiety or mood problems and then just ask additional questions, interview questions based on whatever it is they're collecting.

The data indicated that it is only when others observe the behaviors or the therapists observe them directly that the compulsive behaviors are treated and when the traumagenic connections are resolved the compulsive behaviors do clear up. The response of L illustrated the finding as well.

The response of L to Question 7;

Interviewer: OK, and what are the most significant obstacles in treating clients who have a history of childhood sexual abuse?

Participant L: It seems that the individuals that we encounter that have a history of childhood sexual abuse often have traits of borderline personality disorder so a lot of those traits often will become very prominent while we're providing services here and at times those traits interfere with the treatment, kind of some of the push/pull traits we see and that seems to create a complication.

The dialogue with W also illustrated the finding.

Interviewer: OK, number seven of thirteen; what are the most significant obstacles in treating clients who have a history of childhood sexual abuse?

Participant W: I think for me the major obstacle is because most often the child was abused by someone who was an authority figure in their life.

Interviewer: OK

Participant: And they have always felt that they could not tell that it would be you know a horrible a sin for them to tell and why should they tell because after all this was their authority figure this was something that they have to do, it was a have to do thing like doing your chores and so there was nothing that they could do about it at all which gives them the helplessness, there's also the affect of being traumatized by someone that you feel you trusted, trust has been broken and so there is very little trust out there for anyone else and that's really sad.

The dialogue with B is noted below to further illustrate the finding and indicated how substance abuse or suicidal ideations may develop as traumagenic compulsions, which further complicates the therapeutic milieu:

Interviewer: OK, that's fine though that answers the question, thank you. And number seven of thirteen; what are the most significant obstacles you know of in treating clients who have a history of childhood sexual abuse?

Participant B: The biggest issue that I see here is substance abuse and how that complicates the treatment process for them, it brings up a whole different set of issues for them and also for them being somewhat paranoid, distrustful, willingness to open up and share.

Interviewer: OK, and you may have already answered this, but I'll still ask it again if that's OK, number eight, talk to me about the resistance of treating clients who have a history of childhood sexual abuse.

Participant: I initially would say that we have somewhat less resistance here initially, its probably a more superficial thing though because here, they come in and they're overly emotional, they're most generally suicidal, they're feeling desperate, they're feeling like there's no hope, so they're initially more open with some of the things that have happened to them and once you get past that they start stabilizing some and then you have the traditional, where they start to minimize, she starts, they start talking about distrustfulness, that they have that you think you'd be gaining this and not willing to talk about what's going on with them or talking about things that are somehow related but not really on the surface related.

One would also note that the participants relayed that there was a sense of the immense depth involved in the impact of pain in treating those patients with compulsive behaviors and who have a history of childhood sexual abuse. Thus, there are no easy ways to assess for the behaviors as noted in the responses above.

CHAPTER 5. DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

Introduction

The genesis of this study was the discovery of a gap in the knowledge base regarding traumagenic compulsions that develop and that may be resistant to treatment in patients who have a history of childhood sexual abuse. In the existing literature that described efficacy of CBT in patients, usually around 75% efficacy rates are cited (Hicks & Sales, 2006). As noted in Hicks and Sales, it is possible that the 25% who did not have positive outcomes may have had a history of childhood sexual abuse; however, since it was not assessed due to vulnerability issues in assessment this is unknown.

Discussion of the Findings

Introduction

The first research question sought to explore how vulnerable people can be helped even though resistant to the help. The resistance was stated to be due to the history of betrayal of trust, causing a lack of trust, and trust being so crucial in the therapeutic process. A general consensus among the seasoned clinicians emerged so as to delineate a link between childhood sexual abuse and compulsive collecting and compulsive hoarding. The clinicians indicated that the symptoms noted in the patients with PTSD and OCD due to childhood sexual abuse will not respond to the same treatments noted that usually work in patients with PTSD and OCD due to other etiologies. Thus, a starting

point for a treatment protocol was established. Assessments for correct etiology is crucial and self-reports are not always the guide.

As a result, treatment for something that evades and eludes assessment is difficult to treat. It is also suspected that the younger the abuse occurred, the more difficult assessment and treatment is, even if the person is seeking treatment as an adolescent or adult. The patient may not even realize the core of the problem, yet acknowledges the pain, and so self-reports may be evasive. It is very difficult for patients of any age to articulate a pain that seems to have no physical origin; hence traumagenic compulsions go under-reported. If the trauma occurred before around age eight, it is less readily recalled or articulated. Treatment protocol must rely on core assessment such as projective and expressive techniques and in essence, bypass self-reports. However, once the core issues are identified, the patient needs to give informed consent before the treatments may begin.

Observations

Throughout the data collection and analysis, a theme was continually present in that the drastic results of childhood sexual abuse are present lifelong and a longing exists in seasoned clinicians to have more time to work with this population in order to help them. A search of EBSCOHost for any articles recently published dealing with the topics of the study did not yield any applicable articles. Further implications for each research question of the study now follows.

First research question. How do clinicians assess and treat traumagenic compulsions in patients who have a history of childhood sexual abuse? While a wide variety of methods were voiced, most centered upon formal tools and behavioral

observation. Further, there seemed to be a sense that since each participant has a lack of paid clinical time or reimbursements to fully deal with the patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard as described in the study, the problematic behaviors were not addressed unless the behaviors posed a significant problem to self or others. So there is a sense of “if it is not a problem to the client, ignore it for now” since there is not enough time to completely address the issues. There was acknowledgement that the compulsive behaviors are more than likely a problem to those other than the patient since the behaviors may actually be self-soothing to the patient. Therefore, the behaviors may need to be addressed and assessed in a gentle way to help the patient overcome the compulsive behaviors even though the behaviors may bring a sense of comfort to the patient, but are a problem to others. Consequently, the patient self-reports are not be considered to be totally accurate, at first and secondary reports need to be obtained through signed confidentiality release, in time in treatment.

Participant MAC: I look for their foundation and their experience level and work from there to build so that they can be productive and not let the abuse control them the rest of their lives. Though the OCD behaviors may comfort them, the behaviors may annoy others.

Second research question. How do clinicians describe positive and negative outcomes in treatments of patients who have a history of childhood sexual abuse and who compulsively collect or compulsively hoard?

The sense of relief from pain and a sense of empowerment were repeated themes with 10 of the 10 clinicians reporting positive outcomes in building trust. This is important to note in the field, as some clinicians who do not have success with this population, may try to move too fast with them. As noted earlier, decompensation by the

patient was voiced as a concern or a negative outcome if therapy moved too fast as noted by L below:

Participant L: Ooh, let me think, the resistance, at times it becomes an identity and here we're dealing with such a short period of time average length of stay with a patient with us is 5-7 days and so I may only get to see them for three sessions so that would also be a significant obstacle I guess as well for question number seven, but for question eight, the trust isn't always there and you can't always create the relationship to completely treat that once again we're a stabilization unit so a lot of it is about a lack of time, the time factor that is a problem.

All 10 participants stated a most definite response that childhood sexual abuse leads to compulsive collecting or compulsive hoarding, whether food, compulsive sexual behaviors, self-injurious behaviors, destructive relationships, or specific belongings. The presence of these behaviors may actually be soothing to the patient, while being annoying or painful to others. The behaviors may be injurious to the patient, but since the behaviors have been there since childhood, the behaviors have both painful results and positive payoffs. Since the pain is longstanding, it may not even be registering to the patient as pain any longer. Further, all of the participants agree that CSA is a contributor to compulsive collecting and hoarding, and they do not directly address the traumagenic compulsions unless the client brings it in as a presenting problem because there are other seemingly more pressing behaviors to deal with, according to the patient.

Third research question. What are the most significant obstacles or resistance in treating patients who have a history of childhood sexual abuse and who compulsive collect or compulsively hoard?

The repeated theme found in all 10 of the clinicians in answering the questions within the third research question was in finding ways to fund the lengthy treatment times

needed in dealing with a vulnerable population. Moving too abruptly in the therapeutic process can cause entropic reenactment and can cause the patient to be reminded of the abuse, or seem to re-enact the abuse. Trauma by mere definition literally means a sudden sharp blow and the seasoned clinicians were very cognizant and concerned that none of the therapeutic methods or assessments used remind the patients of the past abuse. Thus, no one subscribed to the method of implosion suddenly removing the possessions or behaviors for the patients and several clinicians voiced that the method of implosion would be contraindicated for this population of patients. All 10 of the seasoned clinicians spoke of taking their time in addressing the issues with the population. The clinicians, who worked in acute care units, stated that to them it might be unethical to even bring up the issues on an acute unit, unless a significant other pointed out any danger to self or others in the behaviors.

The sense of relief from pain and a sense of empowerment were repeated themes in the discussion of positive outcomes in building trust. Seven of the 10 clinicians voiced concerns for decompensation by the patient was voiced as a concern if therapy moved too fast. Concern for resistance in the patients was stated in 10 of the 10 clinicians' responses. The resistance was stated to be an a priori concern as a type of trust issue and for protection from any further pain in dealing with the abuse. This is noted by L below:

Participant L: Ooh, let me think, the resistance, at times it becomes an identity and here we're dealing with such a short period of time average length of stay with a patient with us is 5-7 days and so I may only get to see them for three sessions so that would also be a significant obstacle I guess as well for question number seven, but for question eight, the trust isn't always there and you can't always create the relationship to completely treat that once again we're a stabilization unit so a lot of it is about a lack of time, the time factor that is a problem.

Limitations of the Study

The most serious limitation was the regional limitations of the respondents and the lack of response from participants from a national base. The researcher had hoped for a greater national response from one of the national organizations, but since that did not occur, the findings describe a regional response and condition. Thus, the findings may not generalize to a national patient-clinician base. Further, some acknowledged that since there may not be enough time for them to delve into deeper issues, due to financial or patient self-report constraints, they do not deal with the issue on a daily basis, and their treatment model may be somewhat limited. Some also admitted to a lack of current knowledge of the most recent literature, and were not aware of the recent finding in research to perhaps use the term compulsive hoarding for life-threatening behaviors and compulsive collecting for non-life-threatening behaviors. Another limitation may be in the use of telephone interviews rather than personal interviews, in that while the former does yield viable data, some visual cues and behavioral cues that may have provided important data may have been missed.

Relationship of the Findings to the Literature Review

Conceptual Framework

The research indicated the nature of surviving childhood sexual abuse was a type of betrayal of trust that made survivors a vulnerable population and resistant to treatment and research. Childhood sexual abuse leaves one bewildered and afraid to trust. The bewilderment and discomfoting pain may be re-experienced even when discussing the past events, so that the person has a difficult time in therapy and may miss out on the

benefits of therapeutic interventions due to confusion and emotional dysregulation as a symptom of PTSD. With the lack of trust, the clinician, who is there to help them, cannot help them as a result. People, in general, cloud the emotions and the thoughts of the patient, whereas things or pets do not. Hence the compulsive nature to collect or hoard and the resistance to change as the collecting and hoarding compulsions sooth the patient, the therapist does not. Overcoming that resistance is a skilled learned by some seasoned clinicians over time.

Theoretical Framework

The behavioral approach of implosion was mentioned to be a type of method of re-traumatizing the patient in a way that would remind the patient of the original trauma. As a result, treatment for something that evades and eludes assessment is difficult to treat. It is also suspected that the younger the abuse occurred, the more difficult assessment and treatment is, even if the person is seeking treatment as an adolescent or adult.

Traumagenic resolution therapy needs to precede cognitive behavior therapy for any intervention to be effective in patients who compulsively collect or compulsively hoard and who have a history of childhood sexual abuse. The patient may not even realize the core of the problem, yet acknowledges the pain, and so self-reports may be evasive. It is very difficult for patients of any age to articulate a pain that seems to have no physical origin; hence traumagenic compulsions go under-reported. If the trauma occurred before around age eight, it is less readily recalled or articulated. Treatment protocol must rely on core assessment such as projective and expressive techniques and in essence, needs to bypass self-reports. However, once the core issues are identified, the patient needs to give informed consent before the treatments may begin.

Recommendations for Future Study

In response to the last question of the interview, the participants generally indicated that they would like to inform other clinicians to slow down in the treatment process for the patients' sake. Future research would be plausible to test assessment measures for patients with traumagenic compulsions. As the aging population of America is increasing, and more adults are dealing with the issues of admitting parents into nursing homes, this problem will increase of what to do with all their possessions. The problem will become critical for those parents who have a history of childhood sexual abuse and do not want their possessions taken away too abruptly. Many adults are finding out about these issues too late after their aging parents decompensate due to the sudden loss of belongings where there was emotional attachment. Future studies need to develop protocols for this group of patients as well as those patients who voluntarily seek help or for their spouses or other family members. Future studies also need to help clinicians determine the clear delineation between compulsive collecting that is non-life-threatening and compulsive hoarding that is life-threatening.

The participants in this study stated a most definite response that childhood sexual abuse leads to compulsive collecting or compulsive hoarding, whether food, compulsive sexual behaviors, self-injurious behaviors, destructive relationships, or specific belongings. Future studies to develop a protocol whereby clinicians are directed to almost assume that where there is compulsive collecting and compulsive hoarding, they are to specifically assess for and anticipate a history of childhood sexual abuse. Projective techniques would be most efficacious here as the techniques are more reliable than self-

report, while integrating the latest scale developed by the National Study Group on Chronic Disorganization (NSGCD) (2003) that was also referenced in an earlier chapter. Future studies need to verify and expand the NSGCD Scales (2003) that have developed the four categories of evaluation of compulsive behaviors to include structure and zoning issues, pets and rodents, household functions, and sanitation and cleanliness. Also, there are five levels that indicate the level of severity, which need future research. Typical collecting behaviors of humans would fall into level I or II on NSGCD's scale. On the other hand, there may be a developmental progression among people, some with histories of childhood sexual abuse, to *compulsively collect* (NSGCD level III) and then even *compulsively hoard* (level V). Unlike compulsive collecting, compulsive hoarding is a life-threatening behavior, which when evaluated according to NSGCD's scale, would fall into level IV or V (Frost et al., 2003; Hicks & Sales, 2006; NSGCD, 2003; Pope & Brown, 1998). Therefore, the treatment protocol needs to assess whether a development progression, or addiction exists, and to determine the presence of childhood sexual abuse. The terms collecting and hoarding cannot be used interchangeably in future studies and reports. This would be crucial in the treatment of sex offenders who are reported to see people as objects as noted in an earlier chapter of the study and as noted in Hicks and Sales (2006). Therefore, the future research could lead to research by others that can take the form of perhaps a focus group interview to take place online for clinicians or an online survey to clinicians to develop a treatment protocol for treating various groups of patients with various types of traumagenic compulsions.

Conclusion

There is a pervasive sense that therapy is often rushed with the population of patients who compulsively collect or compulsively hoard and have history of childhood sexual abuse. Due to limited financial/insurance resources, each participant expressed the hope to be able to spend more clinical time with this population of patients as was mentioned in each interview. Third party payers are sometimes faulted for the rush in the treatment process for this population of patients. The hope is to be able to treat the patients without restraints of clinical time and thus, to have unlimited clinical time with this group of patients was often expressed.

In conclusion, the three purposes for using an inductive, qualitative approach are (a) to condense extensive and varied raw text data into brief summaries, (b) to establish clear links between the research objectives and findings, and (c) to develop a model or underlying theory descriptive of experiences or processes (Thomas, 2003). These purposes were obtained in this study. The analysis also kept in mind that Sproull (2002) recommended that the findings of qualitative studies are to be presented in a framework, providing objective and subjective credibility, transferability, dependability, and confirmability. It was seen that these goals were obtained as well even though a regional sample emerged, rather than a national sample of participants. Future research needs to overcome the limitation of this study as it has regional limitations of the respondents and lacks numerous responses from participants with a national perspective.

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APPENDIX A: Interview Protocol

The summary, methods, and questions are as follows;

How clinicians reduce traumagenic compulsive behaviors in people who have a history of childhood sexual abuse.

This research will explore how clinicians have treated traumagenic compulsive behaviors in patients who have obsessive compulsive behaviors in people who have a history of childhood sexual abuse using a combination of cognitive behavior therapy (CBT) and traumagenic resolution therapy (TRT).

Criteria of seasoned clinicians to phone interview;

1. Is a member of American Psychotherapy Association, American Counseling Association, American Counseling Association – Missouri, or Missouri Mental Health Counselors Association.
2. Has been a licensed clinical practitioner for a minimum of 15 years, has treated children, adolescent, adult, or geriatric cases of traumagenic compulsions.
3. Has been trained in and uses a combination of cognitive behavior therapy (CBT) and traumagenic resolution therapy (TRT) as treatment protocol for this specific population.
4. Is presently accepting referrals of patients with traumagenic compulsions due to childhood sexual abuse (the referents' ages may vary according to specialty or any age if general practice).

The questions and answers for the Telephone Interview are to be recorded, transcribed, and are to be analyzed with qualitative analyses using Ethnograph Software.

The proposed instrument would ask the following questions following the laddered question approach:

1. Are you familiar with the terms *compulsive collecting* and *compulsive hoarding*?
2. How do you understand *compulsive collecting* and *compulsive hoarding*?
3. How do you understand traumagenic compulsions?
4. How does *compulsive collecting* and *compulsive hoarding* manifest in your practice?
5. How do you assess traumagenic compulsions?
6. Tell me about your treatment strategies with those clients who engage in *compulsive collecting* or *compulsive hoarding* and who have a history of childhood sexual abuse?
7. What are the most significant obstacles in treating clients who have a history of childhood sexual abuse?
8. Talk to me about the resistance in treating clients who have a history of childhood sexual abuse?
9. What changes could you make in how you treat those clients who have a history of childhood sexual abuse?
10. Tell me about the connection you have seen between childhood sexual abuse, *compulsive collecting*, and *compulsive hoarding*?

11. Tell me of any changes you have seen through working with this population using cognitive behavior therapy (CBT) and traumagenic resolutions therapy (TRT).
12. Do you believe that childhood sexual abuse may be a contributing factor in the development of *compulsive collecting* and *compulsive hoarding*?
13. What would you like to share with other clinicians working with this population?

Thank you!

APPENDIX B: Cover Letter Dear Colleague with Informed Consent Form and The
Structured Interview Questions that were attached

I would appreciate your assistance in my dissertation research. You may be aware that I am completing my Ph.D. in Human Services – General Studies at Capella University. I have completed my classes and comps and now I am in the home stretch. I hope to have at least 10 of the completed structured interviews within three weeks to be on course for the completion of my research.

Please consider forwarding this e-mail with my permission along with the attachments to several clinicians who may be able to assist me by agreeing to complete a structured telephone interview using the questions that are attached. Keep in mind; I am requesting the forwarding of this e-mail to our clinician membership and not clients who might be willing to complete the telephone interview. The clinicians who agree to be participants may e-mail me at alsarno@earthlink.net to agree to the telephone interview and schedule the time.

Criteria of seasoned clinicians to phone interview:

A member of American Psychotherapy Association, American Counseling Association, American Counseling Association - Missouri, or Missouri Mental Health Counselors Association,
has been a licensed clinical practitioner for a minimum of 15 years,
has treated children, adolescent, adult, or geriatric cases of traumagenic compulsions,

has been trained in and uses a combination of cognitive behavior therapy (CBT) and traumagenic resolution therapy (TRT) as treatment protocol for this specific population, and is presently accepting referrals of people with traumagenic compulsions due to childhood sexual abuse (the referents' ages may vary according to specialty or any age if general practice).

The questions and answers for the Telephone Interview are to be recorded, transcribed, and are to be analyzed with qualitative analyses using Ethnograph Software.

More details are provided in the IRB attachment that is to be forwarded along with this e-mail. The IRB attachment applies to you and your agency as well as the clinician completing the survey.

Thank you so much for your assistance. The availability of my results as stated in the IRB attachment applies to you, your agency/organization, and the clinician completing the survey. I hope to have at least 10 of the completed surveys returned within three weeks to be on course for the completion of my research.

Thanks again for your assistance!